



**1991
ADVISORY
COUNCIL *on*
S O C I A L
S E C U R I T Y**

**Commitment to
Change: Foundations
for Reform**

December 1991
Washington, DC





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Commitment to Change: Foundation for Reform

**A Report of the
Advisory Council
on Social Security**

**December 1991
Washington, DC**

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* Resigned, replaced by
John Meagher.

ADVISORY COUNCIL ON SOCIAL SECURITY

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Deborah Steelman, Esq.
Attorney-at-Law

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Executive Director
Ann LaBelle, D.D.S.

The Honorable Louis W. Sullivan
Secretary of Health and Human Services
Washington, D.C. 20201

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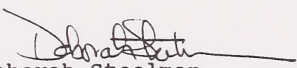
Dear Mr. Secretary:

As required by Section 706 of the Social Security Act, I herewith enclose for transmittal to the Congress and to the Boards of Trustees of the Federal old Age and Survivors Insurance, Disability Insurance, Hospital Insurance and Supplementary Medical Insurance Trust Funds the reports of the Advisory Council on Social Security which was appointed in July 1989. As directed by its Charter, the Council's major findings and recommendations concern a broad and thorough assessment of the factors that bear most importantly on the financial security of American families today and through the year 2020.

When addressing the Council at our first meeting, you urged us to address the current urgent questions of our health care system. You also urged us to assess the ability of current law to meet the challenges of the future and to pose and explore the larger questions the nation must face as it prepares for the largest generation of retirees our country has yet experienced, the Baby Boomers.

On behalf of the entire Council, I would like to extend our thanks to you for the opportunity to address issues of this magnitude and importance to our families and to our children. Additionally, we extend our thanks to Messrs. Stan Ross and David Walker, the Public Trustees of the Federal Old Age and Survivors Insurance, Disability Insurance, Hospital Insurance and Supplementary Medical Insurance Trust Funds for their continuous and important support for our immense task.

Sincerely,


Deborah Steelman
Chair



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

DEC 19 1991

The Honorable Dan Quayle
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

The provisions of Section 706 of the Social Security Act require the appointment of an Advisory Council on Social Security every four years. I appointed the members of the 1989 Advisory Council and charged them with the review of a broad and thorough assessment of the factors that bear most importantly on the financial security of American families today and through the year 2020. Specifically, the Council was asked to assess the ability of the current Social Security, Medicare and Medicaid programs to meet today's challenges and to pose and explore the larger questions the nation must face as it prepares for the largest generation of retirees our country has yet experienced.

To fulfill this charge, the Council undertook a virtually unprecedented review of social security policy, health care policy, savings and investment issues, pension policy, and numerous issues relating to the need to build our nation's economic capacity to provide for the social needs of an increasingly older and more diversified population. Chaired by Deborah Steelman, the members of the Advisory Council, all from the private sector, have worked diligently over the last two and one-half years in a sincere effort to address the issues presented in their reports.

These reports address the full range of the Council's charter. Their recommendations are based on the finding that the best way to ease the burden of paying for future retirement benefits is to increase the productive capacity of the economy.

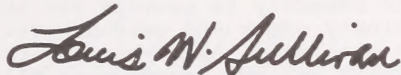
In July of 1990, the Council issued recommendations on Social Security, which were forwarded to you at that time. Their full and final reports were transmitted to me this morning, including their final recommendations on health. Here, the Council's recommendations address four fundamental concerns: the need to improve access to health care for millions of Americans; the need to significantly reduce the rate of growth in health care costs and increase the rate of growth in the general economy; the need

to significantly reform many of the basic institutions involved in the delivery and financing of health care; and the need to fully involve the American people in the development of the American health care system of the 21st Century, without whose support even the grandest plans come to naught.

The Council found that health care is an issue of extreme and immediate importance to the financial security of all American families for two overwhelming reasons: the inequities in our current health care finance and delivery systems; and the unacceptable rate of growth in health care costs. Their review of these significant and unsustainable weaknesses, coupled with their review of long-range economic forecasts and months of public hearings and other outreach, lead the Council to conclude that the sustained financial security of American families rests in substantial degree upon the extent to which we reform our approach to the consumption, delivery, and financing of health care in the United States.

These recommendations should be added to the many proposals already under discussion as we seek health care reform. No one feels more deeply than I the imperative for reform and I believe this report provides a common sense basis from which to debate and act. I look forward to working closely with you to this end.

Sincerely,

A handwritten signature in dark ink, reading "Louis W. Sullivan". The signature is written in a cursive, flowing style with a large, prominent "L" and "S".

Louis W. Sullivan, M.D.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

DEC 19 1991

The Honorable Thomas S. Foley
The Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

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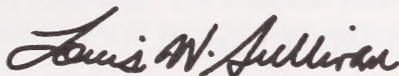
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Sincerely,

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Louis W. Sullivan, M.D.

**STAFF OF THE 1991 ADVISORY COUNCIL
ON SOCIAL SECURITY**

Ann D. LaBelle, D.D.S.
Executive Director

Barbara Cooper

Olga Nelson

Adele Eley

Mary Sue Olcott

Robert Lagoyda

Teddi Pensinger

Arta Mahboubi

Virginia Reno

Susan V. McNally

Nancy Row

Brigitta M. Mullican

Michael D. J. Zambonato

PREFACE

On behalf of the 1991 Advisory Council on Social Security, I would like to extend our profound gratitude for the hard work, long hours and great talent of the Council staff. To Ann LaBelle, our Executive Director, Barbara Cooper, Adele Eley, Robert Lagoyda, Arta Mahboubi, Susan V. McNally, Brigitta M. Mullican, Olga Nelson, Mary Sue Olcott, Teddi Pensinger, Virginia Reno, Nancy Row, and Michael D.J. Zambonato (who kept us laughing when we most needed it!), and to our miracle typists and assistants, please accept our most heartfelt thanks.

When we began this work two and one half years ago, few of us realized the body of scholarly research, issue analysis, and public input that would come to form the basis of our work. The Council's staff assembled a team of economists and actuaries to help us understand the future; they produced 15 public hearings providing us with some of the most valuable insights we received and wrote draft after draft to reconcile our varied comments. The American people are indeed fortunate to have in their service people of such intellect, dedication, and common sense.

We would also like to thank four immensely capable volunteers, Patricia Knight, Mary Ross, David Cooper, and Elizabeth Hadley, who in addition to their full-time work for their agencies, volunteered their time to the Council to make this work one of extraordinary value.

In addition, we extend thanks to several individuals outside the government whose services added depth and weight to our reports: Louis P. Garrison and his staff, Donald Hirsh, David Kennell, Donald Muse, Jack Meyer, and Sean Sullivan.

You did excellent work. For that, we are proud to have worked with you, and we are grateful.

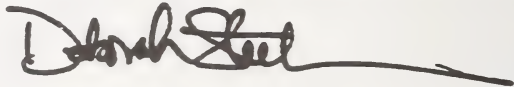
With the volumes of this report, we lay the foundation for a better understanding of the next century. This work prepares us for the challenges the future will bring our Nation as we become an increasingly older society. This work has the potential to change the way people think about the future. This is a great gift to

future retirees, workers, families, and children; indeed, all Americans will benefit now and in the future from the education provided within these pages.

And as the Chair, I would like to extend my personal thanks to my fellow members of the Council. Your time, energy, spirit, and wisdom are evidenced in the many pages of our reports. It was indeed an honor to serve as the Chair, and I will always be grateful for all they taught me.

I would also like to thank the Commissioner of Social Security, Gwendolyn King, for her steadfast support. Throughout the decade in which I have been fortunate enough to enjoy her friendship, she has been a constant source of guidance and inspiration.

Finally, and most importantly, I would like to thank my husband, Gregg Ward, and all of the families of the Council staff. Their constant support through weeks and months of 7-days-a-week, 15-hours-a-day work made our work possible.

A handwritten signature in dark ink, appearing to read 'Deborah Steelman', with a long horizontal flourish extending to the right.

Deborah Steelman
Chair

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EXECUTIVE SUMMARY

The challenge before this country—and every country—is how best to manage its resources for the benefit of its people. As residents of this country, it is our collective responsibility to use our resources wisely in the present and in such a way as to benefit future generations of Americans—our children and grandchildren. If we are sincere in trying to fulfill this responsibility, we must investigate the future without bias and approach the decisionmaking process unselfishly. We must balance the needs of today with the needs of tomorrow. Where resources are limited, we must thoughtfully develop and explore alternatives. While we cannot ignore the needs of today, it is crucial to prepare for the needs of the future.

The image that comes easily to mind when we talk of resources is our natural resources. But this is about different resources: our economic and financial resources, our public and private resources, and, of course, our human resources—the American people. This is about the urgency required to manage our resources to forestall the potential effects of a health care system which may soon dominate our national economy and our personal resources. This is about investing in our country to assure productive growth in a competitive world market. Continuing on our present course will only exacerbate today's problems for the future. Now is the time that we must make a commitment to change. Now is the time to lay a foundation for reform.

This Report represents the deliberations of the 1991 Advisory Council on Social Security. At the request of the Secretary, this Council has taken on a task more broad and challenging than any preceding Council. By expanding its role beyond the important and traditional one of considering issues related

to Social Security to also considering our Nation's health care system, the Advisory Council examined issues that touch families and individuals from every walk of life—the elderly, the child and the working-age adult, the business executive and the employee, the affluent, the middle class and the poor, the sick and the healthy.

The Council's Final Report is deliberately weighted toward the issues of health care. This reflects the Council's concern about the inequities in our current health care financing and delivery system and about the unacceptable rate of growth in health care costs. The Council by no means overlooks the issues of Social Security and its importance to income security. In fact, our systems of health care and income security are inextricably related and fundamental in assuring the financial security of all Americans, a basic Council interest. Ironically, it is the very system of health care, so essential to this fundamental interest, that threatens our ability to sustain financial security for Americans in the future.

The Council's review of the significant weaknesses and unsustainable growth in expenditures of the health care system, combined with long-range economic forecasts, led the Council to conclude that our ability to sustain the financial security of American families rests in substantial degree upon the extent to which we are able to reform our entire approach to using, delivering, and financing our Nation's health care. We can only strengthen our foundation for the future by immediate and parallel commitments to change our health care system and to make the investments necessary to increase our economy's productive capacity.

Findings which informed the debate that brought the Council to this conclusion are contained in this and 12 other reports issued by the Council. Representative findings are interwoven throughout this summary.

Social Security and Income Security

Americans depend on our democratic political process to represent us in the development and shaping of our social systems and to guide the management of our economic and financial resources for our benefit. We can be rightly proud of our accomplishments for the elderly. The Social Security and Medicare programs have contributed remarkably to raising the standard of living among the elderly. Over the past 30 years we have decreased the rate of poverty for the elderly by nearly two-thirds.

Government programs are by no means solely responsible for this achievement. Employers expanded the private availability of pensions so that, now, over 40 percent of the elderly benefit from private pensions. The number of elderly eligible for private pensions in the future is expected to grow. In fact, projections into the future suggest that the elderly will continue to experience real gains in income, in large part because their incomes from Social Security and pensions are projected to reflect real growth in earnings and because more elderly are projected to receive pension benefits in addition to Social Security.¹ Despite this positive overall outlook for the elderly, analysis indicates that variances in elderly income will be significant and that some elderly, particularly the very old and single elderly women, will be particularly vulnerable to poverty.

Americans can be confident about the future of Social Security. A Technical Panel on Social Security² appointed by the Council reported that the Social

¹ Advisory Council on Social Security, *Future Financial Resources of the Elderly: A View of Pensions, Savings, Social Security and Earnings in the 21st Century*, December 1991.

² Social Security Technical Panel reported its findings to the Council in a report dated August 1990.

Security Trust Funds are actuarially sound 50 years into the future. A survey³ about Social Security conducted for the Council found that over three-quarters of those individuals surveyed do not mind paying taxes to support the program.

The Council is pleased by its findings, which indicate both the fiscal solvency and public acceptance of the Social Security program. The Council's specific recommendations on Social Security are at the end of this Summary.

Health Care

Our Present Condition

The image of the Nation's health care system is not as comforting as that of its income security system.

Medicare, which has contributed to the improved financial status of the elderly, pays just 45 percent of the elderly's average total health care expenditures. A Technical Panel on Medicare⁴ reported to the Council that the Medicare Trust Funds are not sound into the future. Alarmingly, most recent projections⁵ indicate that the Medicare Hospital Insurance Trust Funds may be exhausted by 2005.

³ Advisory Council on Social Security, *A Message from the American Public: A Report of A National Survey on Health and Social Security by the Advisory Council on Social Security*, December 1991.

⁴ Advisory Council on Social Security, *Report on Medicare Projections by the Health Technical Panel*, March 1991.

⁵ 1991 *Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, May 17, 1991.

Medicaid, the joint Federal and State program for the most vulnerable of our country's citizens—both young and old—is now the fastest growing item in many State budgets. State health care expenditures for Medicaid recipients average 20 percent of a State's budget. Medicaid consumes up to 40 percent of some States' budgets.⁶ State responsibilities for education, corrections, and other essential services are uncomfortably squeezed, and many States are tightening eligibility requirements and limiting benefits for other programs.

Long-term care poses a special problem. A 65-year-old today has about a 20-percent chance of spending a year or more in a nursing home at an annual cost of roughly \$30,000.⁷ Most people pay long-term care costs on an out-of-pocket basis. As a result of extremely limited public and private coverage for long-term care, many elderly and their families are impoverished by the cost of their long-term care. Many then become eligible for Medicaid. Long-term care now consumes about 43 percent of a State's Medicaid budget. With our rapidly aging population, long-term care will present a financial challenge to our States. It also presents a challenge to families to plan for this expense and a challenge to our Nation to create incentives and programs to ensure effective care for the elderly who need these services.

Americans are expected to spend \$738 billion this year for health care services and the system that provides them; yet the Council heard regularly of frustrations and difficulties that individuals must face when interacting with the system. Hearings⁸ held across the country by the Advisory Council

⁶ Advisory Council on Social Security, *State Governments: The Effects of Health Care Program Expansion in a Period of Fiscal Stress*, December 1991.

⁷ In 1990 dollars, as reported in *The Financing and Delivery of Long-Term Care Services*, ACSS, 1991.

⁸ Advisory Council on Social Security, *A Message from the American Public: A Hearings and Site Visits Report of the Advisory Council on Social Security*, December 1991.

emphasized this as well as individuals' struggles to maintain their insurance and to manage their resources to afford health care. The following highlights from testimony illustrate these issues:

- A Florida businessman has experienced regular increases in premiums over the last 10 years averaging 25 percent per year for six employees, two of whom had dependents. Last year's increase jumped 100 percent—and dropped coverage for the dependents. Finally, the businessman's coverage was not renewed;
- A small-business woman in New Hampshire cannot afford a recent premium increase to \$500 per month per family for her 10 employees. She desperately wished to maintain health insurance coverage for her employees and devoted extensive time to seeking competitive rates. The best she can do is a slightly reduced premium, guaranteed for only 6 months.
- In New Mexico, an elderly woman has high medical expenses not covered by Medicare and avoids having to sign up for Medicaid by scrimping on food.
- The husband of an Indiana woman with Alzheimer's disease describes his extensive efforts to care for his wife at home until he feels it is no longer humanly possible. To pay for the nursing home care she needs would be a nearly unbearable financial burden.
- A woman in New Mexico tells of trying to schedule an appointment with a gynecologist; the first available appointment is 4 months away.

A national survey⁹ conducted for the Council emphasizes the value individuals place on health insurance. The survey reported that over one-fourth of those who received employer-provided health insurance continued to work for their employers because they did not want to lose their health benefits. The survey also reaffirmed for the Council that the large majority of those who feel that they have adequate health coverage do not want their health delivery or their benefits plan altered.

The Council also heard testimony from a wide variety of professional and trade associations, Federal, State, and local agencies, consumer advocacy groups, and health system experts. Each reported thorough and thoughtful investigations into issues of what the health care system's problems are and how to improve it. Not unexpectedly, they all agreed on the problems. Seldom did they agree on the solutions.

Two issues dominate any discussion on health care: the continuing escalation of costs despite public and private sector initiatives to slow the rate of growth and the concern over the number of people who face barriers to obtaining appropriate and needed services. The issues of cost and access are inextricably related: As costs increase, more people are unable to afford health care insurance or the cost of care. Any substantial expansion of coverage to uninsured or underinsured people will add additional costs to the health care system, both in the near term and in the future.

The Council understands that 34.7 million people are without health insurance.¹⁰ Many more individuals are inadequately insured. Insurance is

⁹ Advisory Council on Social Security, *A Message from the American Public: A Report of a National Survey on Health and Social Security by the Advisory Council on Social Security*, November 1991.

¹⁰ From the Office of the Assistant Secretary for Planning and Evaluation, DHHS.

not the answer for everyone, however, for it does not reduce sociocultural and geographical barriers to care. Sadly, one of the largest groups affected by the inequities in our health care system are our children. Over 8 million children were not covered by private health insurance and were either ineligible or did not receive publicly financed medical assistance in 1989. Evidence is limited linking health status and insurance, although twice as many uninsured persons indicate that they are in poor health as do insured persons.

Each year the Nation devotes more and more of its resources to health care. In 1990 health care expenditures represented 12.2 percent of our gross national product (GNP). This represented a 10.5-percent increase from the 11.6-percent share just the year before. Health care expenditures were only 5.3 percent of GNP in 1960.

A Glimpse of Our Future

Concern about our Nation's ability to sustain such growth into the future prompted the Council to appoint an Expert Panel¹¹ to consider what our economic future would be like in 2020 with respect to income security and health care financing. The Panel concludes that the Nation's productivity and real wages will grow but that any gains in income and wealth that we make as individuals and as a Nation will be significantly reduced by the growing resources required to support the health care sector. Fewer and fewer resources will be available for the other critical needs of the Nation.

¹¹ Advisory Council on Social Security, *Income Security and Health Care: Economic Implications 1991-2020—An Expert Panel Report to the Advisory Council*, December 1991.

As an illustration of why the Panel draws this conclusion, consider the following projections, which assume no change in the current system and a continuation of existing laws:

One projection¹² to 2020 indicates that health care could consume 31.5 percent of our GNP. If expenditures actually reach this level, they would place an unacceptable strain on us as individuals and our society. In essence it means that even though our income might grow, our present consumption patterns could not increase; rather, all increases in income would go to health care. Many think health expenditures will never reach 31.5 percent of GNP; however, it is important to note that this projection represents a mere continuation—and not an acceleration—of trends experienced in the past 20 years.

The Panel also reviewed a trend which assumed a significant reduction in the rate of growth of health care costs—of a magnitude we have never experienced—and still health care was projected to grow to 22.7 percent of GNP.

The Expert Panel recognized that these were not true predictions because of the limitations of the assumptions. The Expert Panel concludes, however, that in the absence of major policy change, these projections are plausible.

The Council does not believe that natural market forces will slow the rate of growth of health care to tolerable levels without substantial reform. Historically, health spending between 1976 and 1990 increased by more than

¹² Prepared for the Expert Panel by the Office of the Actuary, Health Care Financing Administration.

twice the rate of growth of our economy.¹³ Each year, we continue to devote more and more of our resources to health care despite serious attempts by the public and private sectors to contain cost growth.

If continued growth in the health sector continues to outstrip increases in wages¹⁴ as anticipated, a few highlights from the Expert Panel's report¹⁵ help us visualize what this could actually mean for our future in 2020:

- For the elderly, the Medicare Part B premium¹⁶ would increase 200 to 300 percent.
- For workers and businesses, payroll taxes¹⁷ for Medicare and Social Security are projected to increase from 15 percent today to between 26 and 32 percent in 2020. Medicare's portion alone may triple or quadruple.
- Private insurers are expected to double or triple the amount they pay out for claims, in real terms. This has implications for individuals and businesses as they struggle to meet the expected premium increases. Benefit reductions or wage reductions could occur.

¹³ Advisory Council on Social Security, *Critical Issues in American Health Care Delivery and Financing Policy*, December 1991.

¹⁴ Real wages are assumed to grow at 1.1 percent while real per capita care spending grows either 3.2 or 4.3 percent, depending on which projection is used.

¹⁵ The following numbers represent analyses of the two projections to 2020 discussed in this executive summary, hence two possible outcomes.

¹⁶ Assumes Part B premium will continue to fund 25 percent of the Part B program.

¹⁷ Part B of Medicare is financed through premiums and general revenues, not by a payroll tax; however, expressing the revenue required as a percentage of payroll is useful.

-
- The percentage of uninsured will increase because of incentives in the system and the disparity between wage growth and growth in health care costs.

The aging demographics of our country will play a role in the redistribution of the share of health expenditures between the private and public sector. The share paid by the public sector will increase, reflecting the extra burden on the Medicare programs and Medicaid for long-term care services.

The major factor underlying projected increases is not demography, however, as is often thought. The growth comes instead from the ongoing evolution in technology, from the way we use services, and from the structure of our health care delivery and financing system.

The Council asked the Expert Panel to consider whether our economy could adequately expand to accommodate the continued growth in health care spending. The Panel concludes that it is unlikely that the United States will experience a growth in the economy that exceeds the projected increase in health care expenditures. Based on an exercise conducted by the Panel, and using the two projections above, the economy would have to grow at least two to three times as fast as projected growth rates per capita,¹⁸ or GNP would have to be 60 to 100 percent larger. Consequently, unless we significantly reduce the growth in health care expenditures, we cannot expect to "grow out" of the effects of rising health care expenditures.

¹⁸ Based on projections used in the 1991 Report of the Trustees of the Federal Old-age and Survivors Insurance and Disability Insurance Trust Funds, May 17, 1991.

Commitment to Reform

The Council is sobered by these observations, as should be every citizen who hears them. The fact that the Nation faces serious health care financing issues does not, however, make the answer any clearer.

Through the processes the Council established to investigate the issues of health care and carry out its charge, the Council heard clearly the voice of the people that health care reform is essential, and the Council agrees. The Council also heard clearly and agrees that quality should not be sacrificed. The Council heard clearly that costs must be appropriately contained and that access to care must be improved. To these, too, the Council agrees.

But the Council also heard clearly that the obvious right choice for reform for one person or group is abhorrent and unacceptable to another. The real implications of change are unclear. The real effects on Americans, our businesses, our economy are unknown. A majority of the Council concludes that, at this time, there is no one right choice. The national consensus so essential to the successful systemic reform the Council believes necessary has clearly not developed.

This is, however, exactly the right time to prepare the country for reform. Now is the time to lay the foundation for change. We are at a critical stage. Tension for reform is high and we have a while—a short while—to contain the emerging crisis brought about by uncontrollable costs and barriers to access. Change can be gradual, but it must be deliberate, focused, and timely. We must tend to the immediate and urgent needs of our citizens, and at the same time we must move systematically forward to the system of our future. To avoid the potential economic consequences of continuing on the same course, so clearly illustrated by the look at 2020, a new and effective

system must be fully operational by the beginning of the next century—less than a decade away.

Health Recommendations

The Council articulated four urgent needs of the Nation's health care system and prepared detailed recommendations to meet these needs:

- The need to improve access to health care for millions of Americans;
- The need to significantly reduce the rate of growth in health care costs and increase the rate of growth in the general economy;
- The need to fundamentally reform many of the basic institutions involved in the delivery and financing of health care; and
- The need to fully involve the American people in the commitment to change by the beginning of the 21st Century.

Two types of recommendations emerge:

First, the Council believes certain changes can and must be acted upon immediately. These are directed at the weakest part of our current system and will not conflict with, but will rather support and strengthen, the foundation for future broad-scale systemic change.

Second, the Council recommends an activist Federal leadership role with a financial investment in our future by supporting and nurturing local and regional solutions for change. The process of developing and implementing

change at community and State levels represents the will of the people. When consensus for reform is achieved, the reform will be perceived as more acceptable and compatible with American expectations for solutions than one that is imposed by the Federal Government.

The Council expects local successes to be evaluated against national criteria that take into consideration not only the needs of today but also the effects on the future. Such an evaluation will yield information about the real implications of reform; it will point to real winners and losers in the system; but, most importantly, it will yield the information we most desperately need to know: What effect will reform have on slowing the rate of growth that seems destined to cripple our economy while at the same time reducing the barriers to access that now confront millions of Americans.

Recommendations to **Improve Access to Care** are directed at our Nation's children and other underserved populations, and are entitled:

- Assist State Departments of Health to establish School Based Clinics for primary care services for children.
- Assist States in offering School Based Major Medical Insurance to complement and supplement care provided through school based clinics.
- Expansion of the Community and Migrant Health Center Program directed at millions of Americans without primary care services.
- Commitment to Reduce Infant Mortality through consolidated and concentrated efforts at all levels of government.

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- Correct Flaws in Private Health Insurance through four separate legislative proposals directed at the most egregious processes now in effect, such as unreasonable premium variations and cancellations due to claims experience or health status.
 - Improve the Portability of Private Health Insurance;
 - Federal legislation to establish new rules for insurance sold to small employers;
 - Disallowance of State-Mandated Benefits for Small Employer Core Benefit Plans; and
 - Preemption of State Laws Limiting the Use of Managed Care in Health Benefit Plans.
 - Increase access to Health Insurance for the Self Employed by changing tax laws to make tax treatment of self-employed equivalent to that of employees.

Recommendations to **Reduce the Rate of Growth of Health Care** through cost-reducing measures and **Build a Stronger Economy** through investing in our human resources and increasing growth in GNP are directed at providing a strong economic system so that we can maintain our standard of living, including a good, affordable health care system.

- Reduce the Federal Deficit to Improve the Productive Capacity of the Economy strongly encourages investment in education, training, human resource development, and capital investment in plant and equipment. Commitment to deficit reduction is critical.
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- Cabinet level Task Force on Investment in Human Resources, to focus attention on and direct action toward altering counterproductive domestic trends.
 - Actions to accelerate promotion of Healthy Lifestyles are presented.
 - Establish a President's Council on Fitness for the Second 50 Years to promote health throughout life in an aging society.
 - Research to Foster Independent Living directed toward facilitating impaired persons to independently perform daily activities.
 - A program to educate, prevent, and treat Preschool and Elementary School Children about Drug and Alcohol Abuse to be developed and implemented by the U.S. Surgeon General.
 - Conduct a massive public education campaign directed at Prevention of Disease.
 - A model secondary school course for Family Financial Management and Financial Planning would be developed to prepare young adults about managing resources for major expenses, including health care.
 - Information on Medical Treatment Outcomes would be required on local and regional health care markets to facilitate assessment and correct weaknesses in manpower and facility resource allocation, use trends, and financing allocations.
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- Alternative Procedure to Adjudicate Malpractice Claims involves a proposal for national administrative tribunal for Federal claims, and a companion proposal applicable to States.
 - Medicare Selective Contracting would establish a process for identifying and certifying high-quality, cost-efficient providers for specific high-cost procedures. Only certified providers would be reimbursed.
 - Medicare Centers of Excellence, which meet rigorous criteria for quality and efficiency, would be established for major surgical procedures. Only designated facilities would be reimbursed.

Reform of Health Care Institutions is directed at reform within the health care system to make it more efficient and effective.

- Establish an Advisory Council on Health Claim Standardization to develop a uniform claim with the intent of reducing paperwork and costs associated with health claims.
 - The Attorney General is directed to revise existing rules limiting Hospital Mergers and Joint Ventures for cases where increased efficiencies could be gained.
 - Merge Medicare Parts A and B, which now are only artificial distinctions and contribute to inefficiencies within the Program.
 - Facilitate Technology Assessment and Data Pooling through an Advisory Group on Technology Assessment Data directed at better understanding and managing technology.
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- Effectiveness Research and Medical Practice Guidelines are to be given broader exposure through development of a medical school curriculum and programs to better inform physicians in their personal practice.
 - Basic Research to Improve Health Outcomes while reducing costs, proposed in the research agenda by the Institute of Medicine, is strongly advocated.
 - To assist individuals facing terminal illnesses, The Medical Directive and Proxy Act would foster reforms and establish a registry containing individual's instructions regarding specified life-prolonging medical procedures.

Specific recommendations for a strategic evolution to reform our health care system follow:

Recommendations to Fully Involve the American People in the development of America's 21st century health care system. Community and regional efforts to address the problems of our health care system are proliferating across the country. These recommendations would strategically support a number of these efforts and other prototype systems identified by the Council.

- Immediately designate a Federal Oversight Commission to identify and support appropriate comprehensive community or State initiatives which would serve as precursors to systemic reform at the national level. A broad range of prototype plans are suggested for consideration:

Comprehensive prototype reforms

- insurance market reform
- all payer model
- employer mandate
- consumer choice
- public/private partnership
- individual tax credit
- universal medical expense
- public health insurance model for acute care

Medicare prototype reforms

- combined acute and long-term care coverage
- Medicare voucher plan

Medicaid prototype reform

- improved access to Medicaid services
 - improved Medicaid enrollment
 - improving Medicaid coverage of the uninsured
- Appropriate and allocate sufficient Federal funds to test and evaluate the prototypes.
 - Evaluate prototypes against common criteria. The Council endorsed criteria developed by the Expert Panel which identify five major objectives and include numerous specific criteria against which proposals for reform should be evaluated. The major evaluation categories are:

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- Effect on Opportunities for Underserved People to Receive Needed and Appropriate Health Services;
 - Distributional Effects of Who Pays in the Near Term and in the Future;
 - Effect on Short-Term and Long-Term Economic Growth for the Nation;
 - Effects of Reform Implementation; and
 - Relationship between Reform and American Culture and Values.
- Report the results of testing and evaluation of the prototypes to the Congress and the President in a timeframe to allow reform to be in place by the end of this century.

Only through nationwide commitment to this process will we focus and gain the consensus on changes necessary for health care reform. Investment in exploring for the best alternatives is the only way to ensure that resources will be available for a future American health care system that can serve our residents.

Social Security Recommendations

- The Economy and Social Security
 - Deficit Reduction. The Council supports removing Social Security from the calculation of deficit reduction targets to focus attention on the rest of the budget.
 - Trust Fund Revenues. No action now.
 - Reserve Investment Policy. Continue current policy in U.S. securities.
- Financial Status of the Trust Funds. The system is soundly financed through the next 50 years.
- Scope of Coverage and Adequacy of Benefits
 - Coverage of State and local employees. Mandate coverage for all new hires.
 - Women and Minorities. Issues related to these groups warrant examination and oversight. The Commissioner of Social Security should convene a task force for each group.
 - Technical Panels. Periodic assessment of the soundness of long-range assumptions for Social Security and Medicare should be continued.

THE WORK OF THE 1991 ADVISORY COUNCIL ON SOCIAL SECURITY

Health and Human Services Secretary Louis Sullivan, M.D., appointed the Advisory Council on Social Security in 1989, directing that it undertake a wide and thorough assessment of the fundamental factors which bear on the financial security of American families through the year 2020.

In addressing the Council's first meeting, Secretary Sullivan urged a broad examination, extending beyond the statutorily mandated review of current law to encompass not only the crucial issues of our current health care system today, but also the larger questions facing the United States as it prepares for the largest generation of retirees the world has ever known—the baby boomers.

To fulfill its charge, the Council determined to undertake an unprecedented review of Social Security and health care policy, savings and investment issues, pension law, and numerous issues related to our Nation's ability to build sufficient economic capacity to provide for the social needs of an increasingly older and diversified population.

To guide its work, the Council developed a statement of principles for the economy, Social Security, health care, and reform of health care financing and delivery. These principles were a framework for the Council's deliberations, and we believe they should be the foundation of today's debate on income security and health care policy. Our guiding principles follow.

Principles for the Economy, Social Security, and Health Care

- The productive capacity of the economy must be strengthened in order to increase real income, improve our positions in international market competitiveness, and lessen the burden of the costs of health care and social insurance programs in the future.
- Changes in retirement income and health care policy should not impede economic growth in the short term or long term.
- Changes in policy should be flexible enough to accommodate future demographic changes.
- The costs of income security and health care should be distributed equitably.
- All Americans and their families should be able to have some protection against financial insecurity even when family earnings cease because of disability, death, retirement, or job loss or when they are faced with significant acute or long-term health care costs.

Health Care Reform Principles

- All Americans should be able to obtain necessary health care.
- The rate of growth in health care expenditures should be reduced.
- Health care services should meet enhanced standards of cost-effectiveness without compromising quality.

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- All Americans should be encouraged to adopt healthier lifestyles.
 - A commitment should be made to address environmental and social factors affecting health.
 - Governments should adequately fund their health care program commitments.

For its comprehensive review, the Council assembled expert panels which studied specific, technical issues; it held 10 public hearings and 73 site visits across the Nation, soliciting a wide range of public input at each stop; and it deliberated the more narrow issues contained in 18 analytical papers examining topics ranging from long-term care to school-based clinics.

The product of this exhaustive examination is detailed in the final report and in 12 separate documents which represent substantive, scholarly investigations into the issues the Council identified as central to its debate. These reports may be grouped into three broad categories: technical and expert panel reports, public input, and issue analysis. While executive summaries of these reports are printed in appendix A, a brief outline of each follows.

Technical and Expert Panel Reports

The Council assembled three panels of independent consultants to study the future of the Social Security and Medicare programs and the combined long-term effect on the Nation's economy of impending demographic changes, pension trends, savings rates, and Social Security and health spending. Each study was carried out by economists and actuaries who

assessed the adequacy of the assumptions and projections used for trust fund estimates.

- **The Social Security Technical Panel Report**, published in July 1990, concluded that the OASDI Trust Fund is generally sound for the next 50 years.
- **The Report on Medicare Projections by Health Technical Panel**, reviewing Medicare projections, found that the Hospital Insurance Trust Fund faces a huge long-range financial deficit and concluded that it cannot support current rates of spending: "To secure stable long-term financing will require balancing the burden that is to be borne by beneficiaries and by working-age taxpayers both now and in the future . . . policy makers should consider options for improving the financial status of Medicare not solely in terms of annual budget policy, but rather in terms of structuring the best possible health care program for the aged and disabled given the amount of resources that society is willing to allocate to it."
- **Income Security and Health Care: Economic Implications, 1991–2020—An Expert Panel Report to the Advisory Council on Social Security** focused on the year 2020 and the impact of baby boomers' retirements and of other demographic changes on income security and health spending. The report paid particular attention to the effect of the continuing rapid growth in health care costs, citing the fact that in 2020 the combined cost of the Social Security and Medicare programs (including Part B) will represent 32 percent of taxable payroll and health care expenditures will consume 22 to 32 percent of GNP. Analysis of several plausible scenarios shows GNP would have to be 60 to 100 percent larger in 2020 and

real per capita GNP would have to grow at a rate 2.6 to 3.4 times greater than currently projected in order to accommodate the projected growth of health care expenditures and the projected consumption of other goods and services. The Panel urged immediate attention to reducing health care growth trends and increasing growth in the general economy, noting that the United States will not be able to accommodate the projected growth in health expenditures and still maintain the consumption patterns and living standards we enjoy today.

Public Input Reports

Two reports contain findings about public attitudes and opinions on a range of Social Security and health care issues. One report summarizes the Council's 15 hearings and 73 site visits, covering over 25 cities and towns across the United States. The other contains the results of a national survey the Council commissioned to assess the level of public knowledge on and opinions about Social Security, Medicare, the American health care delivery and financing systems, and a number of health care reform plans under discussion today.

- **A Message from the American Public: A Hearings and Site Visits Report of the Advisory Council on Social Security** revealed that the majority of the public believes that Social Security should remain an important part of the retirement income system in the United States, although many suggested improvements in the program ranging from increased benefits to a drastic restructuring. The public expressed generally favorable opinions about Medicare and Medicaid, although they indicated problems with reimbursement rates, gaps in coverage,

and eligibility requirements. Many barriers to health care were described, including language, cultural differences and perceptions, lack of transportation, and the uneven distribution of health care professionals. The report highlights the many positive examples the Council heard of efforts that public hospitals, community health centers, and school-based clinics are taking to care for the uninsured, the elderly, and the poor.

- **A Message from the American Public: A Report of a National Survey on Health and Social Security by the Advisory Council on Social Security** scrutinized the knowledge and opinions that over 2,400 Americans hold on Social Security and health care. Almost three-quarters had a favorable impression of Social Security, although a majority of those not currently receiving benefits believe the system will not have funds to pay benefits when they retire. A 58 percent majority favored continuing the program as presently constructed, and a full 78 percent say they do not mind paying taxes to support the program. Over three-quarters expressed satisfaction with their health insurance and the quality of their health care, with more than 60 percent stating that the current system needs either no changes or only minor ones. Most indicated that health care is a right of all Americans and, when questioned on alternate reform proposals, responded similarly to each.

Issue Analysis Reports

The Council assessed a number of specific issues which in their totality provided an understanding necessary to make recommendations commensurate with the Secretary's broad charge.

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- **The Interim Report on Social Security and the Federal Budget**, published in July 1990, both emphasized the need to reduce the Federal deficit in order to increase the productive capacity of the Nation's economy and supported current rates and methods of financing the trust funds. The Council concluded that "the best way to ease the burden of paying for future retirement benefits is to increase the productive capacity of the economy."
 - **Critical Issues in American Health Care Delivery and Financing Policy** contains 18 analytical papers which served as background briefing documents for the Council's discussion and formulation of recommendations. Its papers, summarized below, span three broad areas: access to care, cost containment, and health care financing and delivery in other countries.
 - **Profile of the Uninsured and Underinsured** studied the size and characteristics of the uninsured and underinsured populations and examined the consequences of uninsurance in terms of access to care and the costs of health care;
 - **Private Health Insurance** analyzed the growth and structure of private health insurance in the United States, the major issues confronting it as a market, and the implications for coverage;
 - **Public Health Insurance** reviewed the Medicare and Medicaid programs, their limitations in providing health care coverage, and their role in health care reform;
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- **The Role of Direct-Financed Services** examined the major providers and sources of funding for direct services and the role of direct services in health care reform;
 - **The Problem of Long-Term Care** studied such long-term care problems as catastrophic costs, the lack of risk pooling, access, and quality of care, the factors that contribute to each problem, and their consequences;
 - **Health Insurance Reform for Small Employers and High-Risk Individuals** surveyed the major categories of health insurance reform proposals and their implications for coverage;
 - **Medicaid Expansion** described proposals for Medicaid expansions and their potential impact on cost and access;
 - **The Role of Schools in Expanding Access to Care** researched the roles schools can play in expanding access to care and how these efforts might be financed;
 - **State Initiatives to Expand Access to Care** reviewed the reform options that have been enacted or are being considered at the State level;
 - **Options for Financing Long-Term Care** developed a framework for assessing long-term care reform options and applied the framework to alternative proposals;
 - **Approaches for Financing Expansions in Access to Care** addressed eight different sources of financing: payroll taxes,
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personal income taxes, taxing some employer-provided health insurance benefits as income; a value-added tax (VAT), "sin" taxes, such as excise taxes on alcohol and tobacco, national lotteries, user taxes, and estate and gift taxes;

- **The Problem of Rising Health Care Costs** looked at health care costs and experiences with efforts to contain them;
- **Controlling the Costs of Administration** examined the components of the administrative costs system and their impact on health care delivery;
- **Containing Health Care Costs through Supply and Price Controls** studied efforts to contain health care costs in the United States through supply and price controls and examined their effectiveness;
- **Managed Care as a Cost-Containment Vehicle** described the fundamental elements of managed care as a cost-containment vehicle by defining the concept of managed care, outlining principal managed care strategies employed by health care purchasers, and describing and analyzing specific managed care programs;
- **Health Care Rationing** discussed the many difficult and complex logistical, legal, and ethical problems associated with non-price rationing of health care;
- **Cost Containment and Quality of Care** examined the evidence of the impact on cost and quality of care of two strategies:

incentives to influence provider behaviors such as reimbursement incentives designed to influence them to use fewer resources, and incentives to influence consumers, such as increased patient cost-sharing;

- **Health Care Delivery in Other Countries** evaluated the health care delivery systems of four countries and examined the nature and success of their approaches to reducing health care costs while attempting to maintain access and quality; and
- **Future Financial Resources of the Elderly: A View of Pensions, Savings, Social Security, and Earnings in the 21st Century** assessed the critical question for future generation retirement planning: "What will be the source of future retirees' income and how much income will that be?" The report is based on a proprietary pension model which projects to the year 2020 the elements of the "three-legged stool" of retirement income security—pensions, private savings, and Social Security. The analysis indicated that variances in elderly income will be significant and took a particularly pessimistic view for unmarried women above age 85. However, it also showed that the elderly as a group will continue to improve their financial condition and, both in terms of real income and real assets, be better off than the elderly of today. The most serious questions were posed about inadequate personal savings rates and the validity of assumptions about employer pensions.
- **Social Security and the Future Financial Security of Women** focused on the status of retired women based on data from multiple sources, including the pension model referenced above, public hearings, and information provided by the technical and expert panels.

It recommends further assessment of specific questions necessary to improve the financial status of older women.

- **The Influence of Current Judicial Doctrines on the Cost of Purchasing Health Care** discusses both malpractice-related costs and the need to identify and measure the potential impacts on health care spending of a variety of unconnected legal decisions in such areas as antitrust, right-to-die, and experimental treatment.
- **State Governments: The Effects of Health Care Program Expansion in a Period of Fiscal Stress** discusses the effects of the increase in health care costs from two different State-level perspectives: eight individuals involved in State budgetary decision-making processes provide first-hand views of social spending and the stress that rising health care costs have placed on their budgets, and a national analysis of State budget decisions and the ensuing tradeoffs in social spending is presented.
- **The Financing and Delivery of Long-Term Care Services: A Review of Current Problems and Potential Reform Options** discusses the issues involved in financing and delivering home and long-term care based on data from several sources, including a dynamic microsimulation model of long-term care. The report presents several options for reforming today's long-term care financing and delivery systems.

STRENGTHS AND WEAKNESSES OF THE INCOME SECURITY AND HEALTH CARE SYSTEMS

The Council began its examination of this country's income security and health care systems by a careful evaluation of the strengths and weaknesses inherent in each. On the positive side, the Council found that the Social Security system, which enjoys a high measure of public support, is adequately financed for at least the next 50 years. The American health care system also enjoys a number of strengths, including superior medical institutions providing high quality care, and a general public satisfaction with the quality of services and insurance coverage provided.

On the other hand, the Council identified several groups especially vulnerable to inadequate retirement income, found disturbing trends in the costs of old age, survivors, and disability insurance (OASDI) program, as the baby boom generation retires, and encouraged the use of trust fund reserves to promote economic growth. The health care evaluation revealed more alarming trends, including the dire effects on the economy if health costs continue to rise relentlessly, indications that the HI trust fund will be depleted by 2005, a near-crisis in the availability of State funds for Medicaid, the implications of health care spending on national productivity and competitiveness, and a large number of Americans who lack health insurance or who face other problems in receiving care.

Details of the Council's observations follow:

Strengths in Income Security

Social Security

Social Security, fundamentally a very strong system, is the most important income security program in the country and enjoys widespread public support.

To provide a thorough review of the assumptions and methodology used to project the future financial status of the old age, survivors, and disability insurance (OASDI) programs, the Advisory Council appointed a Panel of Technical Experts on Social Security. The Panel concluded that **the Social Security system is adequately financed for at least the next 50 years.** Moreover, the OASDI trust funds are projected to have increasing dollar reserves over the next 37 years. The Technical Panel also concluded that the Office of the Actuary of the Social Security Administration is highly competent and that the methods and assumptions used for the official projections are reasonable and sound.

The importance of these findings cannot be overemphasized. Social Security provides the primary source of income for 92 percent of elderly families and will continue to do so in the future.¹⁹ Almost 62 percent of elderly families currently rely on Social Security for at least half of their income; the "oldest old" (those elderly aged 85 and above) rely on Social Security more heavily.

¹⁹ The estimates of income and wealth contained in this chapter are taken from estimates provided by Lewin/ICF based on the Pension and Retirement Income Simulation Model (PRISM). These figures are discussed in more detail in the Advisory Council's reports on *Social Security and the Future Financial Security of Women and Future Financial Resources of the Elderly: A View of Pensions, Savings, Social Security and Earnings in the 21st Century*, December 1991.

In the year 2018, a similar but slightly smaller percentage (58.2 percent) of elderly families will receive half or more of their total income from Social Security, and it will continue to be a particularly important source for the oldest old. Almost one-half (46.9 percent) of the elderly aged 85 and over will rely on Social Security for 80 percent or more of their total income.²⁰

These estimates and projections confirm that the Social Security program has successfully established an income floor for the elderly population and constitutes the linchpin of the Nation's income security system. The program ensures a retirement income for the vast majority of Americans.

Another important, though less tangible, strength of the Social Security program is the widespread public support that it enjoys. **A substantial percentage of the American public has a favorable impression of the program in its current form.** The Advisory Council's survey showed that a significant number of those surveyed (73 percent) had either a "very favorable" or "somewhat favorable" impression. Moreover, a majority of those surveyed (58 percent) think that the program should be maintained in approximately its current form.

Although Social Security will remain the most important component of retirement income for most Americans in the coming 30 years, their economic security will be enhanced by several additional factors. Both the income and the wealth of the elderly are expected to increase in the period 1988 to 2018. PRISM simulations indicate that the family incomes of the elderly will increase by almost 50 percent in real terms (1988 dollars) and that median family income will increase nearly 60 percent over the next

²⁰ Advisory Council on Social Security, *Future Financial Resources of the Elderly: A View of Pensions, Savings, Social Security, and Earnings in the 21st Century*, December 1991.

30 years. The median total income (in constant 1988 dollars) for all family units aged 65 and over is projected to increase from \$11,770 in the 1986-1990 period to \$18,760 in the 2016-2020 period. This change is due, in large part, to the fact that earnings-related benefits from Social Security and pensions are projected to keep pace with the assumed growth in real wages.²¹ In fact, the projected 1.3 percent annual increase in the average income of elderly families during this period will exceed the assumed 1.1 percent annual increase in real wages.²²

Pensions and Savings

An analogy of the retirement income system has been made by envisioning a three-legged stool, in which Social Security, employer-provided pensions, and individual savings are the three legs of the retirement income stool. After Social Security, pensions are the second most important source of retirement income. As of 1988, 46 percent of all full-time private sector employees and 75 percent of all government employees participated in a pension plan. The proportion of all workers covered (including part-time workers) was 44 percent, with 29 percent holding a vested right to a pension in 1988.²³

Both the number of employers offering pension plans and the number of workers covered by a pension plan expanded dramatically during the late 1950s and early 1960s. Between 1950 and 1965, the number of plans increased eightfold and the number of covered workers increased 22 percent.

²¹ Advisory Council on Social Security, *Income Security and Health Care: Economic Implications 1991-2020—An Expert Panel Report to the Advisory Council on Social Security*, December 1991.

²² Advisory Council on Social Security, *Future Financial Resources of the Elderly: A View of Pensions, Savings, Social Security, and Earnings in the 21st Century*, December 1991.

²³ Advisory Council on Social Security, *Income Security and Health Care: Economic Implications 1991-2020—An Expert Panel Report to the Advisory Council on Social Security*, December 1991.

As of December 1989, employer-sponsored pension plans had reached an estimated \$2.8 trillion in value. Nearly 66 percent of these funds were from private employers. Of the private employer pension funds, more than a third (36 percent) was invested in corporate equity, another third was held in insured reserves, and the remaining third was held in bonds, cash, and other assets. Overall, pension funds hold about 9 percent of total financial assets held in the United States.²⁴

In 1988, nearly 40 percent of all elderly families received income from either a public employer or a private employer pension plan. Among those receiving a public or private pension, the average benefit amount was \$8,000 per year. Overall, pension income represented about 17 percent of the aggregate income of the elderly.²⁵

Employer pensions will become a more important component of the income of the elderly in the future. The fact that more elderly families will receive pension income is the critical factor causing an annual increase in average income among the elderly that exceeds the growth in real wages over the next 30 years. The percentage of elderly families receiving pension income is expected to increase dramatically and rise from the approximately 40 percent of elderly families who currently receive pension income to 76 percent by the year 2018.²⁶

²⁴ Ibid.

²⁵ Advisory Council on Social Security, *Future Financial Resources of the Elderly: A View of Pensions, Social Security, and Earnings in the 21st Century*, December 1991.

²⁶ Ibid.

An important factor that will increase pension coverage is the continuing expansion of women's participation in the labor force, coupled with their employment for longer periods in industries that offer pension coverage.²⁷

Individual Savings

Overall, about 24 percent of the aggregate income of the elderly is derived from individual efforts to save.²⁸ Nearly 73 percent of all elderly families have income from assets, but less than 2 percent have income from an IRA. For those having asset income, the average amount was about \$5,900, while the median was much smaller, at \$900.

In 1988, the median net worth for the elderly was estimated to be \$73,471. Approximately 40.4 percent of this was home equity and 22.4 percent was held in interest-earning assets at financial institutions. Nearly 75 percent of the elderly owned their own homes.²⁹

In sum, the PRISM projections indicate that elderly families will have fairly substantial increases in their income over the next 30 years. The average and median income of elderly families will increase at a rate faster than the assumed rate of increase in real wages. However, the roles of different income sources will not change significantly.³⁰ Although pensions are expected to assume increasing importance, Social Security will continue to constitute the primary source of income for most elderly families. Social Security will remain the most important component of retirement income, supplementing all of the other sources.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Ibid.

³⁰ Ibid.

Strengths in Health Care

The Council found a number of strengths in the American health care system; its quality of care and level of medical technology available are second to none. American medical institutions are among the world's best. For those who can pay and/or have adequate insurance, the U.S. health care system offers some of the finest care available in the world. Patients have access to the latest and best technology and do not endure long waiting periods before obtaining nonemergency treatment.

There are many hospitals and medical schools located throughout the country, and a number of them are the world's leaders for particular specialties and treatments. The quality of medical education in this country is superb and ensures that American doctors are highly trained professionals. Other health professionals are also well educated, and all health professionals are carefully regulated to ensure that the public receives treatment only from qualified practitioners.

The United States is a leader in both medical and pharmacological research. The achievements of American universities and other institutions in biomedical research have made them preeminent in the world and have greatly contributed to the quality of care available in this country. The U.S. Government has provided significant financial support to biomedical research, in large part through generous funding of the National Institutes of Health, whose achievements are well-documented.

Eighty-six percent of the population has at least some health insurance,³¹ and nearly all of the elderly in the United States are covered by Part A of Medicare. These figures indicate that the Medicare program has succeeded in providing insurance to a segment of the population likely to need health care, and that reliance on nongovernmental sources of insurance has provided coverage to a significant majority of Americans.

Most Americans are satisfied with the quality of the health care services that they receive. The results of the Advisory Council's survey indicate that 78 percent of those polled were either "very satisfied" or "somewhat satisfied" with the quality of their health care services. **Moreover, the majority of Americans are satisfied with their own health insurance coverage.** The same survey indicates that 78 percent of those polled were either "very satisfied" or "somewhat satisfied" with the quality of coverage provided by their health insurance. The majority of those surveyed were also generally satisfied with such features of their insurance as the amount of required paperwork (59 percent) and their own costs (55 percent).³²

Another strength of the American health care system is its ability to utilize all sectors of the economy—public, private, and nonprofit—to meet the needs of a large and diverse population. In the course of conducting hearings and making site visits throughout the country, the Advisory Council learned of many innovative programs run by public, nonprofit, and volunteer entities. Hospitals, community health centers, and other community-based programs provide significant amounts of care to uninsured and underserved populations.

³¹ Unpublished data derived from the March 1991 Current Population Survey.

³² Advisory Council on Social Security, *A Message from the American Public: A Report of A National Survey on Health and Social Security by the Advisory Council on Social Security*, December 1991.

For example, a number of public hospitals have developed innovative programs to control costs and improve the care provided to their communities. At Cook County Hospital in Chicago, the Emergency Department is conducting clinical research to reduce emergency room admissions of asthma patients. Lincoln Hospital in the South Bronx has undertaken outreach activities to serve vulnerable populations in the community. And at Boston City Hospital, a group of five doctors, assisted by social workers and public health nurses, makes traditional house calls in order to provide primary care in the community. The efforts of public hospitals to meet the health care needs of the poor and uninsured are particularly commendable in light of the significant fiscal constraints facing these institutions.

Community health centers, many of them federally funded, also provide significant amounts of health care to underserved populations. In addition, certain community hospitals have established neighborhood clinics and support them without the assistance of Federal grants. Two such clinics exist in Boston. In other communities, groups of health care professionals volunteer their time to staff clinics that provide free care. Such clinics exist in St. Petersburg, Florida, and Chicago, Illinois.

Volunteers are also responsible for the existence of other invaluable health care organizations, including ambulance squads that provide emergency medical services, hospices, and shelters for the homeless and for abused children. Together, these entities and organizations play a significant role in meeting the diverse needs of different communities.

Weaknesses of the Income Security and Health Care Systems

Despite the strength of the Social Security program, the projected improvement in the financial status of the elderly, and the numerous positive features of the American health care system, there are a number of negative facts and trends that jeopardize the long-term security of the population.

Income Security

Social Security. Not all Americans who receive Social Security are as well protected as they should be. In the year 2018, as today, several groups will remain especially vulnerable: widows and widowers, single people living alone, and people with low incomes.³³ The elderly over age 85 and women living alone are especially at risk of having inadequate incomes. In addition, the Council recognizes that minorities as a group also lack adequate income.

It is not just the Social Security income of these groups that places them at risk, it is also the relative size of their total income and assets. The elderly are not a homogeneous group in terms of their relative wealth. Age and marital status have an important influence on an individual's financial security. Unmarried women have a lower median income in 1988 than do unmarried men or married couples, and they are projected to have smaller growth in median income by 2018. The oldest old are most likely to be unmarried women, and their median income is below that of younger elderly. Specifically, the "young elderly"—those aged 65 to 74—have median income

³³ Advisory Council on Social Security, *Social Security and the Future Financial Security of Women*, December 1991.

that is nearly double that of the oldest old in 1988. The difference between the young old and the oldest old is projected to widen by 2018. This widening gap results in part from the fact that the younger elderly will include more women who have substantial work histories. Another important factor is that the young elderly will receive Social Security and pension benefits that are linked to more recent earnings levels.³⁴

The cost of OASDI will rise beginning with the retirement of the baby boom generation and is not expected to decline as succeeding generations retire. The demographic shift that will occur when the baby boom generation retires will cause the cost of OASDI, as a percentage of taxable payroll, to rise in the next century.³⁵ Between 2010 and 2030, the number of persons of retirement age will grow more rapidly than the number of persons of working age. This demographic shift is the result of high birth rates in the 1950s and 1960s, followed by low birth rates in the 1970s and 1980s. Projected increases in life expectancy will also contribute to a larger number of retirees in the next century.³⁶ An important consequence of this shifting age structure of the U.S. population is the change in the ratio of covered workers to OASDI beneficiaries. This ratio is expected to decline from 3.4 workers per beneficiary in 1990 to 2.4 in 2020.³⁷

The shift to a lower ratio of workers to retirees is not a one-time phenomenon of the baby boom generation's retirement. It is expected that

³⁴ Advisory Council on Social Security, *Social Security and the Future Financial Security of Women and Income Security and Health Care: Economic Implications 1991–2020—An Expert Panel Report to the Advisory Council on Social Security*, December 1991.

³⁵ Advisory Council on Social Security, *The Interim Report on Social Security and the Federal Budget*, July 1990.

³⁶ Ibid.

³⁷ 1991 Annual Report of the Board of Trustees of the Federal Old-Age and Survival Insurance and Disability Trust Funds, May 17, 1991.

birth rates will remain low and mortality rates will continue to improve; consequently, the ratio of workers to retirees is projected to remain relatively stable as the baby boom generation is succeeded by subsequent generations. Thus, the cost of Social Security as a percentage of taxable payroll is not expected to decline after the baby boom generation leaves the benefit rolls; there is no peak followed by a later drop in cost.³⁸

The accumulation of reserves in the OASDI trust funds will not reduce the burden or costs of Social Security in the future unless the reserves are used in ways that help promote economic growth. If the buildup in Social Security reserves is used simply as a substitute for other fiscal policy actions that are needed to reduce the Federal budget deficit, the growing reserves will not contribute to growth. Other fiscal policy actions, such as increasing government revenues or reducing government expenditures, are necessary; otherwise, the future pool of goods and services will be no larger than if there had been no partial advance funding of Social Security.³⁹

Pensions and Savings. The trend toward increased pension coverage in the next 30 years is a positive finding, but various uncertainties about the future of private pensions may diminish the impact of this trend. For example, the assumptions underlying the PRISM projections do not take into account the degree to which pensions are unfunded or underfunded.⁴⁰

Economic changes may affect the value of pensions and thus the adequacy of pension income for the elderly. The value of pensions may be eroded in

³⁸ Advisory Council on Social Security, *The Interim Report on Social Security and the Federal Budget*, July 1990.

³⁹ Ibid.

⁴⁰ Advisory Council on Social Security, *Income Security and Health Care: Economic Implications 1991–2020—An Expert Panel Report to the Advisory Council on Social Security*, December 1991.

several ways. When a worker leaves a job with a vested right to a future pension, the ultimate pension amount does not keep pace with changes in wage or price levels between the time the worker leaves the job and the time the pension is actually paid. Consequently, a worker who earns pensions on a series of different jobs over a lifetime will have significantly less income from pension benefits than a worker who has continuous service in one pension plan. The value of pension income for a worker who changes jobs periodically may also be affected by the lack of portability of most pensions. These workers may face the loss of nonvested benefits.⁴¹

Secondly, the value of pensions can be eroded by inflation that occurs after retirement. Most pension plans do not provide regular adjustments to keep pace with post-retirement inflation. According to the Department of Labor, fewer than 30 percent of participants in private defined benefit plans and only 75 percent in State and local plans have cost-of-living adjustments (COLAs). These COLAs are valued, on average, at 60 percent of the consumer price index (CPI). Without full cost-of-living adjustments, pensions decline in real terms as the pensioner ages, and the decline has the greatest impact on the oldest old. For example, a 4-percent inflation rate would reduce the real value of a pension by one-half in approximately 18 years if the pension lacked a COLA provision. Such a reduction would dramatically reduce the resources of a retiree who lived to age 83 but began collecting the pension at 65. The issue of protection against inflation will grow in importance as the number of oldest old increases.⁴²

A defined benefit plan, a retiree's pension income is not entirely secure. The Pension Benefit Guaranty Corporation (PBGC) had a significant deficit for

⁴¹ Ibid.

⁴² Ibid.

FY 1990. Although premiums have been increased in an effort to eliminate this deficit, it could persist into the next century. Another cause for concern is the potential default of the assets funding the plan. For example, recent experience indicates that assets in the form of deposits in savings and loan institutions or investments in real estate, commercial mortgages, and junk bonds are now overvalued.⁴³

The same concern about the deterioration in the value and performance of assets applies to defined contribution plans. Such deterioration is serious for these plans because the individual participant bears the investment risk directly, unless the employer makes up any defaults.⁴⁴

These uncertainties will affect the adequacy of the pensions paid to retirees in the year 2018 and temper the positive finding that many more elderly will be entitled to pensions 30 years from now than are today.

Assets. The value of asset holdings of the elderly is expected to increase over the next three decades, but the distribution of financial resources will remain highly concentrated. The median value of all financial assets (i.e., all assets other than home equity) is projected to increase from \$2,210 in 1988 to \$7,210 in 2018. Despite this increase, however, the overwhelming majority of the aggregate financial assets of the elderly (about 85 percent) will be held by those in the top fifth of the financial asset distribution.⁴⁵

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid.

Coverage of State and Local Government Employees

State and local government employees are covered under Social Security through voluntary agreements with the Secretary of HHS and each State. Many employees of State and local governments are not covered by any retirement plan and lack valuable Social Security coverage. This makes such workers particularly vulnerable for the following three reasons:

- They may lose eligibility for disability or survivors benefits because of lack of portability of coverage;
- The worker will have gaps in coverage for Social Security retirement benefits which could result in lower benefits or even ineligibility for such benefits; and
- In the event they are not covered by any pension plan, they may reach retirement without a source of income.

Health Care

There will be significant adverse effects on the entire economy if the cost of health care continues to rise unabated. The increase in the cost of health care is critical because of the implications of such increases to both the American health care system and the American economy as a whole. The unrelenting rise in the cost of health care and the rate of increase are the most critical problems facing the American health care system.

From the perspective of both society and the individual, the benefits from future gains in income and wealth are significantly compromised by the growing resources required to support the health care sector. The Nation

cannot continue its current consumption patterns and devote an ever-increasing share of GNP to health care expenditures. The demand for resources will substantially exceed what our economy can produce. Moreover, a combination of factors makes it unlikely that the U.S. economy will grow at a rate exceeding the projected increase in health care expenditures.⁴⁶

The projections of the two technical panels appointed by the Advisory Council indicate that in 2020, the cost of Medicare and Social Security together will be roughly equivalent to 32 percent of taxable payroll under one projection and 26 percent of taxable payroll under another, compared with 15 percent today. This startling fact has sobering implications. It will significantly reduce individual savings and will lower the tax base. The increased expenditures for health care and support for social programs for the elderly will undoubtedly offset the income gains expected to be experienced by **workers**. Expenditures for health care could also seriously erode the income and assets of the **elderly** and offset the income gains that they are projected to experience. If out-of-pocket health care costs paid for by the elderly continue to rise at the same rate as other health care costs, the average Medicare beneficiary could spend nearly 48 percent of their Social Security benefit and over 22 percent of their total retirement income on health care. These expenditures do not include payments for long-term care.⁴⁷

In addition to the general problem of rising costs, at least three other factors jeopardize the financial structure of the Nation's health care system and

⁴⁶ Ibid.

⁴⁷ Ibid.

threaten the entire economy. First, the 1991 Trustees Report indicates that the Medicare Trust Funds for Part A will be depleted by 2005.⁴⁸

Second, the Medicaid program is approaching a crisis in many States.

Medicaid is a means-tested entitlement program based on complex eligibility criteria that provides payment for a variety of health care services to the eligible needy. It is jointly funded by the Federal and State governments, but the States are the administrators of their own programs. States administer their individual programs within broad Federal guidelines. The fiscal problems experienced by the Federal Government and by many States have made it difficult to fund this program adequately. The problem is complicated by the fact that Federal guidelines require the States to provide certain services. States generally cannot pay hospitals and providers adequate rates, with the result that there are insufficient providers to serve all those eligible for Medicaid and/or to provide them with all the services to which they are legally entitled.

Third, the cost of long-term care may pose a substantial burden for many families in the next 30 years. Nearly half of all nursing home care expense is paid for directly out of pocket. Estimates indicate actual per capita out-of-pocket costs could double by 2020. Approximately two of every five persons surviving to the age of 65 are estimated to experience a stay in a nursing home. A 65-year-old today has about a 20-percent chance of spending a year or more in a nursing home at an annual cost of roughly \$30,000.⁴⁹ As a result of extremely limited public and private coverage for long-term care, many elderly and their families are impoverished by the cost

⁴⁸ Social Security Administration, *1991 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, May 17, 1991.

⁴⁹ In 1990 dollars, as reported in Advisory Council on Social Security, *The Financing and Delivery of Long-Term Care Services: A Review of Current Problems and Potential Reform Options*, December 1991.

of their long-term care. At this point, many become eligible for Medicaid. The aging population will likely place additional strains on the Medicaid budget.

The financial problems facing the American health care system are not its only weaknesses. **Fourteen percent of the American population are uninsured.** This percentage represents approximately 34.7 million people—a figure greater than the population of many countries, including Canada. The large percentage of Americans who lack health insurance constitutes one of the two most serious weaknesses of the current health care system. The solution to this problem is complicated by the most serious weakness—the problem of rising costs.

Access to the health care system is difficult or impossible, even for people who have insurance, because of a maldistribution of providers. The country does not have an adequate number of primary care physicians, especially in rural areas and inner cities. In addition, many small, rural communities have found it impossible to support a local hospital. The lack of providers and hospitals in certain geographic areas prevents people from obtaining care even when they have insurance to pay for it.

The access problem is exacerbated for Medicaid beneficiaries because physicians often limit the number of Medicaid patients that they will treat. Physicians name several reasons for their reluctance to treat Medicaid patients. One significant factor is the low rate that States pay them to treat such patients. Low reimbursement rates, coupled with extensive paperwork and long delays in receiving payment, make it difficult for physicians to maintain economically viable practices if they treat a high percentage of Medicaid patients. Another common complaint is that Medicaid patients are difficult to treat. They do not consistently follow physicians' instructions,

they do not keep appointments, and they may be high-risk patients because of factors such as substance abuse, inadequate diet and housing, and tobacco use. As a result, Medicaid patients have a high risk of adverse outcomes, especially pediatric and obstetrical patients. Physicians are unwilling to risk the potential legal liability inherent in treating such patients.

These negative facts and trends are alarming, even when evaluated in the context of the overall strength of the American income security and health care systems. The following chapters contain a systematic analysis of both these systems.

FACTORS AFFECTING THE HEALTH CARE FINANCING AND DELIVERY SYSTEMS

The costs of health care by any measure are high and growing at a rapid rate. In 1990, total health care spending reached \$666 billion, or \$2,566 per person, and consumed 12.2 percent of the gross national product (GNP).

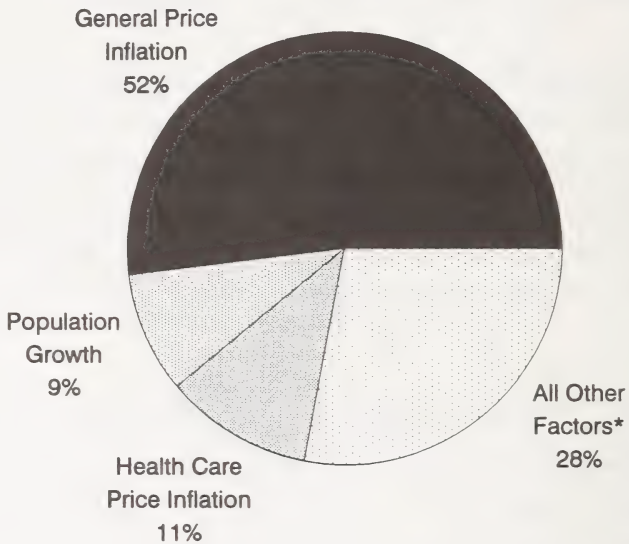
Over the last 20 years, personal spending for health care rose at an average annual rate of 11.6 percent. General inflation in the economy accounted for 52 percent of this growth, while another 11 percent resulted from increases in medical care prices above the general inflation rate. Greater utilization and "intensity" of health care services contributed another 28 percent to overall spending growth, and population increases accounted for the remaining 9 percent.

Although inflation, utilization, and intensity are elements that have been identified with health care spending, the underlying factors that comprise these elements contribute heavily to health care expenditure growth. Many of these factors are external to the health care system itself. Demographic, environmental, legal, cultural, and behavioral factors are all responsible in part for increased health care spending. They are also equally troublesome in their negative effect on health status and access to health care.

Other factors driving up spending are intrinsic to the health care financing and delivery systems: insurance coverage and third-party payments; the numbers, types and distribution of providers; Federal tax policies; and continual improvements in and ready availability of medical technology all

Chart 1

Components of Projected Health Spending
(Percent Distribution)
1970 - 1990



* All other factors includes increases in utilization and intensity of services, including increases due to changes in the age and sex composition of the population

Source: Levit, et al., "National Health Expenditures, 1990," *Health Care Financing Review*, Vol. 13, No. 1.

contribute to higher spending. In order to solve the nation's health care problems, it is important first to understand the factors causing them.

External Factors

The External Environment

Today's health policy debate focuses on reforming the health care delivery and financing systems. It almost literally ignores the external environment in which these systems operate. This external environment includes the changing demographic composition of American society, individual genetic makeup, lifestyle and behavior choices, environments in which Americans live and work, and the interaction between the American health care and legal systems.

The contribution of external factors to increased health care costs, declining health status, and reduced access to care has been recognized but has proven difficult to quantify. Principally because deficiencies in the health care financing and delivery systems are more readily quantifiable and more widely discussed, the health care reform debate has centered on reforming these systems and has almost ignored an examination of external factors and their influence.

Health care financing and delivery systems are often relied upon to overcome the effects of factors which these systems control either inefficiently or not at all. Most analyses do not acknowledge the limitations or costs of requiring financing and delivery reforms to address factors outside the health care system. These factors affect the health care system and together can impair health status, increase demand for services, raise costs, and create barriers to

obtaining care. These factors should be examined in any serious discussion of health care costs and access.

Demographic Trends

The aging of populations in all advanced industrial nations affects their health care financing and delivery systems. In 1988, the remaining life expectancy for all races and sexes at 65 years was 16.9 years.⁵⁰ The baby boom generation in the U.S. will be moving into its retirement years between 2010 and 2030, and life expectancies are expected to continue to rise. The number of people aged 65 and over is expected to increase from 32 million in 1990 to 53 million by 2020, or from 12 percent to 16 percent of the total population. By 2040, this group will number 72 million and comprise 20 percent of all Americans. Moreover, the number of "old-old"—those aged 85 and over—is expected to increase even more rapidly, from 3.2 million in 1990, to 6.2 million in 2020, to 11.8 million in 2040.⁵¹

A decline in overall health status is expected as a natural result of aging. The number of disabled elderly—those with limitations on their ability to perform such daily activities as eating, dressing, bathing, and going to the toilet—will more than double over the next 50 years, exceeding 13.5 million by 2040.⁵²

⁵⁰U.S. Department of Health and Human Services, National Center for Health Statistics, *Health United States - 1990*, March 1991.

⁵¹Advisory Council on Social Security, *Income Security and Health Care: Economic Implications 1991-2020—An Expert Panel Report to the Advisory Council on Social Security*, December 1991.

⁵²*Ibid.*

It has been estimated that demographic changes will account for only about 10 percent of the overall projected rise in the share of the GNP attributed to health. The aging of the population will, however, significantly affect public and private spending under Medicare and for long-term care. Per capita health care spending for the elderly is substantially higher than that for children or younger adults; in 1987, it was 3.5 times the level for working-aged adults and about seven times that for children.⁵³ Furthermore, the growing number of disabled elderly will create greater demand for long-term care services both in nursing homes and in the community. The number of disabled elderly requiring nursing home care is projected to increase from 1.5 million in 1990 to 2.6 million in 2020. And the number of elderly needing assistance to live at home or in community-based settings is projected to nearly double during that same period, from 5.6 million to 10.1 million.⁵⁴ The growing disabled population living in the community will generate more demand for both formal care from paid providers and informal care from family caregivers.

Genetics

Each individual has a unique genetic makeup, and the total American population has a wide range of predispositions towards various ailments. Gender, for example, affects life expectancy: in 1988, the life expectancy for men was 71.8 years; for women, 78.5 years.⁵⁵ Family histories display common risk factors for a variety of diseases, including cancer and heart disease. The genetic makeup of individuals has a profound impact on the health care financing and delivery system.

⁵³Ibid.

⁵⁴Ibid.

⁵⁵U.S. Department of Health and Human Services, National Center for Health Statistics, *Health United States - 1990*, March 1991.

Individual Lifestyle and Behavior Choices

Many choices individuals make about their lifestyles—about physical fitness, nutrition and diet, smoking, abuse of alcohol and other drugs, and sexual behavior—put them at higher risk of serious illness. Resultant increases in serious illnesses often cause increased spending for health care.

For example, most Americans have a sedentary lifestyle, despite the common knowledge that physical activity helps to prevent or at least to alleviate such conditions as heart disease, hypertension, diabetes, and osteoporosis. Currently, only 22 percent of adults engage in at least 30 minutes of light or moderate physical exercise five or more times per week, while nearly 25 percent do not exercise at all.⁵⁶

Nutrition and diet also affect health status. Diets high in fat have been shown to be associated with coronary heart disease.

Use of tobacco products has been shown to cause cancer and heart disease, with associated increases in health care costs. Tobacco use accounts for one out of every six deaths in 1988—or 434,000 deaths annually—and, in addition to cancer and heart disease, is a major risk factor for chronic bronchitis, emphysema, and respiratory infections.⁵⁷ Smoking during pregnancy is responsible for an estimated 17 to 26 percent of low birth weight babies, 7 to 10 percent of premature deliveries, and about 5 to

⁵⁶U.S. Department of Health and Human Services, *Healthy People 2000*, September 1990.

⁵⁷U.S. Department of Health and Human Services, Centers for Disease Control, *Mortality and Morbidity Weekly Report*, February 1, 1991.

6 percent of infant deaths.⁵⁸ Recent Federal studies concluded that smoking costs the nation \$52 billion annually or \$221 per person per year.⁵⁹

Use of alcohol and other drugs is another personal behavior choice that impairs Americans' health and increases societal spending on health care. Alcohol is linked to approximately one-half of all homicides, suicides, and automobile accidents.⁶⁰ Deaths from esophageal cancers and liver disease are other consequences of alcohol abuse.⁶¹ Fetal alcohol syndrome is one of the leading causes of preventable birth defects and affects as many as three of every 1,000 live births.⁶² The total annual cost to the nation of alcohol abuse for 1990 was estimated at \$136.3 billion.⁶³

Drug abuse has an increasingly serious impact on individuals' health status and results in increased demands for treatment. According to a 1990 survey conducted by the National Institute on Drug Abuse, 1.6 million Americans had used cocaine in the last 30 days, and 10.2 million had used marijuana in

⁵⁸U.S. Department of Health and Human Services, Office on Smoking and Health. *Health Benefits of Smoking Cessation - A Report of the Surgeon General*. Washington, D.C., 1990.

⁵⁹U.S. Department of Health and Human Services, Office on Smoking and Health, *Report To Congress, National Statistics - Second Edition*, Section 2, February, 1990.

⁶⁰Perrine, M.; Peck, R.; and Fell, J. *Epidemiologic Perspectives on Drunk Driving* at the Surgeon General's Workshop on Drunk Driving, Background Papers. Washington, D.C., U.S. Department of Health and Human Services, 1988.

⁶¹American Healthcare Systems, Inc., *Challenges for Change - Patients First: A Report and Recommendations*, December 1991.

⁶²U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism, *Sixth Special Report to the U.S. Congress on Alcohol and Health*, Washington, D.C., 1987.

⁶³U.S. Department of Health and Human Services, *Seventh Special Report, Alcohol and Health*. January, 1990.

the last 30 days.⁶⁴ At least 351,000 drug abusers were in treatment in 1989⁶⁵ at a cost of \$888 million to the American taxpayer.⁶⁶

Drug use increases the risk of violent behavior resulting in injuries, of contracting the AIDS virus, and of developmental problems in babies.⁶⁷ Each year, 375,000 drug-exposed babies are born costing an estimated \$6.5 billion each year. Infants of drug-addicted mothers may be born with complications that affect their health for the rest of their lives. The costs of drug abuse to the Nation were estimated to be \$44 billion in 1990.⁶⁸

Violence

Violent and abusive behaviors also injure individuals' health and increase health care spending. Suicides and homicides are responsible for over 33 percent of the 145,000 deaths from injuries. In each year between 1979 and 1986, violent assaults caused more than 2.2 million non-fatal injuries. One million of the injured received medical treatment, and 500,000 were treated in emergency medical facilities.⁶⁹ Over 65,000 people are admitted annually for gunshot wounds alone.⁷⁰ Gunshot wounds and other assault injuries cost \$4.4 billion each year. Family violence, usually directed at

⁶⁴U.S. Department of Health and Human Services, *National Household Survey of Drug Abuse*, National Institute on Drug Abuse, Alcohol, Drug and Mental Health Administration, Public Health Service, Rockville, MD, 1991.

⁶⁵U.S. Department of Health and Human Services, National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, *Main Findings - Report of National Drug and Alcoholism Treatment Unit Survey*, 1989.

⁶⁶National Office of Drug Control Policy, *1990 Drug Control Strategy*, Budget Summary, 1990.

⁶⁷*Healthy People 2000*, op. cit.

⁶⁸U.S. Department of Health and Human Services, *NIDA Census*, September 30, 1990.

⁶⁹*Healthy People 2000*, op. cit.

⁷⁰*Ibid.*

women and children, also results in injuries. More than one million women seek medical care every year for injuries caused by domestic beatings.⁷¹

Sexual Behavior

Almost 12 million Americans annually, 86 percent of whom are between the ages of 15 and 29,⁷² are affected by sexually transmitted diseases—most commonly HIV, gonorrhea, syphilis, and genital herpes. The most serious complications of sexually-transmitted diseases include AIDS, pelvic inflammatory disease, sterility, blindness, infant deaths, mental retardation, and birth defects. The total cost (exclusive of AIDS) to society exceeds \$3.5 billion annually.⁷³

AIDS, which is contracted through sexual activity and needle use, has substantially increased health care spending. As of September 30, 1990, 145,056 cases of AIDS had been reported by State health departments, with 90,914 deaths.⁷⁴ An estimated one million people in the United States are estimated to be infected with the HIV virus.⁷⁵ The cost of AIDS care ranges from \$25,000 to \$30,000 per patient, and the annual costs are projected to be between \$5 and \$13 billion in 1992.⁷⁶ These figures range

⁷¹U.S. Department of Health and Human Services, National Institute of Mental Health, Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, *National Family Violence Survey 1985*, Rockville, MD.

⁷²U.S. Department of Health and Human Services, Centers for Diseases Control. *Division of STD/HIV Prevention Annual Report*, 1989, Atlanta, GA: U.S. Department of Health and Human Services, Rockville, MD.

⁷³*Healthy People 2000*.

⁷⁴*Health United States - 1990*.

⁷⁵*Healthy People 2000*.

⁷⁶Mason, James O., M.D., *Public Health Considerations: A Progress Report*, presented at AIDS/Frontline Health Care Conference, 1989.

widely due to differences in numbers of infected individuals and the progress of the disease.

Environmental Conditions

Environmental conditions such as air and water pollutants and safety at home and in the workplace also contribute to a decline in health status and increase in health care spending. Exposure to air pollution, for example, contributes to lung diseases, asthma, eye irritation, cancer, and neural disorders.⁷⁷ In 1988, only about one-half of Americans lived in counties that met all Environmental Protection Agency standards for air quality during the preceding 12 months.⁷⁸

Home. Three million children in the United States are at some risk from exposure to elevated lead levels, particularly children living in inner-city urban areas.⁷⁹ Lead poisoning is estimated to cost the United States more than \$28 billion over the next 26 years.⁸⁰ Another environmental risk factor in the home is exposure to radon gas, which can damage lung tissue and lead to lung cancer. An estimated eight million homes may have levels of radon gas requiring correction, but only 5 percent of homes have been tested.^{81 82}

⁷⁷U.S. Environmental Protection Agency. *Environmental Progress and Challenges: EPA's Update*, Washington, D.C., August 1988.

⁷⁸U.S. Environmental Protection Agency, *National Air Quality and Emissions Trends Report*, 1988 EPA - 450/4-90-002. Washington, D.C., August 1988.

⁷⁹U.S. Department of Health and Human Services, Agency for Toxic Substances and Disease Registry. *The Nature and Extent of Lead Poisoning in the United States: A Report to Congress*, Washington, D.C., July 1988.

⁸⁰U.S. Department of Health and Human Services, Centers for Disease Control, *A Strategic Plan for Elimination of Childhood Lead Poisoning*, February 1991.

⁸¹*Environmental Progress and Challenges*, op. cit.

⁸²*Healthy People 2000*, op. cit.

Work Place. Injuries in the workplace, as well as exposure to substances that increase workers' risk of disease, also increase health care spending. An estimated 10 million workplace injuries occur annually, 3 million of them severe. In 1987, 1.8 million workplace injuries resulted in total disability, and 70,000 resulted in permanent impairments.⁸³

Health problems resulting from workplace exposures include occupational lung disease, skin disorders, and cancers.⁸⁴ Service sector jobs, which are an increasingly large part of the American economy, also involve workplace hazards, including indoor air pollution, radiation from computers, and stress.⁸⁵

Motor Vehicles. Deaths and injuries from motor vehicle and other accidents are another cause of higher health care spending. The total cost to the United States from injuries, including lost productivity and medical care, has been estimated at \$100 billion annually. One of every six hospital days and one of every 10 hospital discharges result from non-fatal motor vehicle injuries.⁸⁶ Approximately 46,000 people die and 3,500,000 are injured annually in motor vehicle accidents,⁸⁷ yet only 42 percent of Americans report that they use seat belts.⁸⁸ In 1986, according to the National Highway Traffic Safety Administration, failure to wear seat belts cost society about \$900 million in medical care.⁸⁹

⁸³U.S. Department of Labor, Bureau of Labor Statistics, *Annual Survey of Occupational Injuries and Illnesses*, Washington, D.C., 1988.

⁸⁴*Ibid.*

⁸⁵*The Future of Work and Health: Implications for National Health Strategies*, Institute for Alternative Futures, March 1987.

⁸⁶*Healthy People 2000*.

⁸⁷*Ibid.*

⁸⁸*Healthy People 2000*.

⁸⁹American Healthcare Systems Inc., *Challenges for Change - Patient's First: A Report and Recommendations*, December 1991.

Poverty. Poverty is an important environmental factor linked to decreased health status and increased health care costs. Almost one of eight Americans lives in a family with an income below the Federal poverty line, and nearly a quarter of children under age six are members of such families.⁹⁰

Individuals who live in poverty have higher rates of heart disease, arthritis and rheumatism, hypertension, asthma, diabetes, emphysema, cancer, and injury and death from trauma than those whose income is above the Federal poverty line.⁹¹

The effects of poverty on health status are reflected in infant mortality rates. During the Council's regional hearings and site visits, witnesses in nearly every location testified that infant mortality, poor birth outcomes, and low birth-weight babies were problems associated with women in poverty. Significant costs are associated with low birth weight babies; one study estimated that every low weight birth prevented by early prenatal care saves between \$14,000 and \$30,000.⁹²

Low-income Americans generally have had less access to delivery of preventive care such as neonatal care and immunizations, which have proven cost-effective. Measles vaccinations alone have provided a net savings of \$5.1 billion over the first 20 years of their use. But with increasing poverty among U.S. children and declines in immunizations, childhood illnesses are increasing.⁹³

⁹⁰*Healthy People 2000*. Op cit.

⁹¹*Healthy People 2000*.

⁹²Fahs, Marianne, "The Economic Consequences of Sanction," in *Imminent Peril: Public Health in a Declining Economy*, Twentieth Century Fund Press, 1991.

⁹³*Ibid.*

The American Legal System. The health care financing and delivery system must operate within the larger context of a legal system that increases health care costs in several ways. Mandates on insurers to cover particular services, medical malpractice judgments that raise premiums and increase the practice of "defensive medicine," and antitrust laws that impede elimination of duplicative health care facilities—all result in higher spending for health care.

Health insurance policies generally agree to pay for treatments ordered by a physician that are "reasonable and necessary" in treating an illness—i.e., in accord with generally accepted standards of medical practice. Almost all health insurance policies explicitly exclude coverage of experimental or investigational treatments.

Despite such explicit exclusions, courts have ordered insurers to pay for such expensive treatments as bone marrow transplants for breast cancer patients, for which there is little clinical evidence of replicable success. Courts have also ordered insurers to pay for the treatment of cancer with vitamins and Laetrile, even though most physicians, as well as the Food and Drug Administration, do not consider these treatments effective. These judicial decisions increase costs by extending coverage to additional services, thereby adding to total expenditures. Because insurers cannot anticipate these decisions, they raise premiums to protect against unanticipated losses.

Judicial decisions in medical malpractice cases have also raised health care costs. In the 1980s, the frequency of malpractice claims and the size of awards dramatically increased, driving up the cost of medical malpractice insurance. Since 1985, average professional liability premiums have increased at an average annual rate of 13.9 percent for all physicians. The average professional liability premium in 1989 was \$15,500, but for

obstetricians and gynecologists it was \$37,000.⁹⁴ Professional liability insurance costs represented 4.9 percent of total practice revenues for all self-employed physicians in 1989 and was nearly twice that for general surgeons, obstetricians, and gynecologists.⁹⁵

As another probable consequence of high malpractice verdicts, physicians increasingly practice "defensive medicine" by ordering tests or procedures either to minimize the risk of being sued or to provide an appropriate defense if suit is brought. Surveys show a wide range of estimates of the costs attributable to defensive medicine—from 5 to 20 percent of total health care spending. The American Medical Association estimates that 14 percent of physician service expenditures in 1985 may be attributed to defensive medicine.⁹⁶

Malpractice litigation has also encouraged physicians to avoid risky procedures or stop practicing in certain specialties. This is most evident in obstetrics and gynecology, where an increasing number of physicians limit their practice to gynecology and no longer perform obstetrics.⁹⁷ Moreover, malpractice decisions add to health care costs by creating a legal climate in which the standard of appropriate care becomes the best available medical practice, rather than what is done in a particular community. This has resulted in greater use of high-cost technology. Obstetricians, for example,

⁹⁴Slora, E.J. and Gonzalez, M.L., AMA Center for Health Policy Research, "Medical Professional Liability Claims and Premiums, 1985-1989," in *Socioeconomic Characteristics of Medical Practice 1990/1991*.

⁹⁵Gillis and Willkee, "Practice Cost Shares of Self-Employed Physicians," in *Socioeconomic Characteristics of Medical Practice 1990/1991*, AMA Center for Health Policy Research, Table 2, p. 23.

⁹⁶AMA Center for Health Policy Research, Slora and Gonzales, *Medical Professional Liability Claims and Premiums*, 1991.

⁹⁷Meyer, Sullivan, and Silow-Carroll, *Critical Choices: Confronting the Cost of American Health Care*. A Report to the National Committee for Quality Health Care, Washington, DC, 1990.

have increased their use of electronic fetal monitoring, at least partially owing to a fear of liability.⁹⁸

Product Liability

Product liability litigation also increases health care costs when patients who have been treated with a particular drug or medical device sue the manufacturer when an unforeseen medical consequence occurs, claiming that the drug or device is responsible. By one estimate, product liability contributes about 4 percent of the sale price of a medical device. In some cases, manufacturers have withdrawn products from the market altogether because of liability concerns. In addition, it is difficult to quantify the impact that such litigation has on the willingness of manufacturers to bring new products to market.

Antitrust. Antitrust laws contribute to increased health care costs when providers are prevented from merging to reduce excess capacity or duplication of services. They must continue to maintain excess capacity, adding its capital and operating expenses to total health care costs.

Summary. Important external forces create the environment in which the health care financing and delivery systems operate. These forces include changing demographics, individual lifestyles and behavior choices, the environments in which people live and work, and the American legal system. They are largely beyond the reach of financing and delivery system reforms, yet have serious impacts on health and on spending for health care.

⁹⁸Advisory Council on Social Security. *The Influence of Current Judicial Doctrines on the Cost of Purchasing Health Care*, 1991.

Internal Factors

Financing Factors

The health care financing system contains perverse incentives that increase health care spending. They are found throughout the system and affect everyone—providers, suppliers, consumers, insurers, businesses, and government.

Most Americans have either private or public health insurance. In 1990, about four-fifths of all medical services were paid for by private insurers or by the government (primarily Medicare and Medicaid).⁹⁹ Third-party coverage protects against catastrophic financial losses and helps to assure that people can afford health care services. Much of the current debate over health care centers around finding ways to extend insurance coverage to the 14 percent of Americans who are uninsured. The financial protection provided by insurance, however, also changes the economic incentives for consumers and providers, and the debate must also address the issues raised by these incentives.

Health insurance, unlike most other forms of insurance, pays for services received rather than losses sustained by the insured. If individuals do not have to pay much of the cost of services, they have little incentive to economize on the use or cost of those services.

⁹⁹Katherine R. Levit, Helen C. Lazenby, Cathy A. Cowan, & Suzanne W. Letsch. "National Health Expenditures," 1990. *Health Care Financing Review*. Vol. 13, No. 1, Fall 1991.

It is generally believed that expansion in the extensiveness of third-party reimbursement of health care costs, including private insurance, tends to reduce the incentive for patients and their physicians to be cost-conscious in making decisions about the use of medical services. The nature of our governmental subsidies to promote the purchase of health insurance tends to exacerbate this tendency, particularly if these subsidies promote the use of a low level of copayment which, in turn, leads to increasing utilization. This results in a trade-off between higher insurance premiums and the cost of additional services of relatively low benefit.

Federal Tax Policy. Private health insurance coverage has been stimulated by Federal tax policy. Employers can deduct the cost of health insurance as a business expense, and employees do not have to declare this contribution as personal income. The Department of Treasury calculates that this tax subsidy typically reduces the cost of health insurance by over 30 percent. The value of the subsidy increases as workers move into higher tax brackets. One estimate shows that families making over \$100,000 receive government subsidies equal to about one-fifth of their acute care expenditures.¹⁰⁰ A significant portion of this subsidy is a result of the tax policy.

If the tax preference were reduced or limited, individuals would become more concerned about the cost of their insurance and of medical services. In a life-threatening situation, they would elect to be treated regardless of the cost or whether they were covered. In other instances, however, individuals might avoid such high-cost, non-emergency, elective procedures as vein stripping and ligation to correct varicose veins, or select catastrophic-type insurance policies that exclude some health services or have high deductibles.

¹⁰⁰Unpublished estimates from Lewin/ICF.

Benefit Design. Benefit packages and cost-sharing requirements can also increase health care spending by not promoting the most cost-effective settings or medical procedures. If there is no patient cost-sharing connected with hospitalization but there are deductibles and coinsurance for outpatient care, for example, the patient has an incentive to be hospitalized even if outpatient care is just as beneficial and less costly.

Medicare covers most surgical procedures but not outpatient prescription drugs. Even if drug therapy is a viable and less costly alternative to surgery, the incentive is still to have surgery. Medicare also covers long-term intravenous therapy in a hospital or nursing home but usually not in the patient's home. In Council hearings, a physician testified about a depressed patient who wished to be home, but was unable to afford intravenous therapy—which would have been less costly to society as well as more beneficial to the patient.

Similarly, Medicaid covers nursing home care, but in many States does not cover home- or community-based services. These settings are less costly than nursing home care in some instances, but the financial incentive encourages institutionalization.

Rules intended to constrain costs sometimes have the opposite effect. Some insurers still require and pay for second-opinions prior to elective surgery despite studies indicating that second-opinion programs actually increase insurance costs by 5 to 8 percent.¹⁰¹

¹⁰¹Feldstein, Paul J., Thomas M. Wickizer, and John R.C. Wheeler. "Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures." *New England Journal of Medicine*, (19 May 1988).

Payment Policies. Methods for paying providers and suppliers can also increase costs. Most insurers still pay providers on a fee-for-service basis: the more services they perform, the more they earn. A few physicians may perform more services than necessary to maximize reimbursement, but for the vast majority of physicians the desire to please patients and give them the highest quality treatment push them to do more, rather than to provide only necessary or effective care. They have incentives to use every available medical remedy for the terminally ill, even when doing so does not improve functioning or the quality of life.

Recently, third-party payers have been changing some of their payment methods in an attempt to alter financial incentives. Managed care arrangements in the private sector and prospective payment to hospitals under Medicare are good examples.

Technology Explosion. The importance of technological change in the health sector is evident to the most casual observer, as each day we are bombarded in the media with information on new drugs, devices, and procedures. More subtle changes in the organizational structure and delivery of medical services (such as HMOs and increasing specialization) are no less important and certainly more pervasive. Measuring with any precision the relative impact of either the hundreds of small technological changes or the more broad systemic changes is extremely difficult. Furthermore, attempts to distinguish among these types of changes have met with little success. The best estimates indicate that a major share, but not all, of the changes in intensity might be attributable to technological change.

The range of beneficial diagnostic and therapeutic interventions has been expanding rapidly for several decades. Bypass surgery; heart, liver, and cornea transplants; and artificial knee and hip implants are but a few

examples. Many interventions, however, do not have dramatic potential to cure or prevent a major category of disease. Instead, even though they may be technologically sophisticated and complex, they introduce only marginal improvements in the ability to treat disease, often at a very high cost (i.e., a newer generation of magnetic resonance technology may offer a limited additional benefit to the physician).

A new medical technology does not usually reduce spending because, in addition to the capital cost involved, it also generates new costs for operation and maintenance. Diagnostic therapies such as MRI, for example, require not only the facility in which images are made, but also technicians trained in the proper use of the equipment and physicians who understand the new "output." The costs of operating new equipment often exceed the amortized cost of the equipment itself. Rarely does a technological innovation decrease the number of services provided by physicians; new therapies often increase a physician's base of patients and supplement rather than replace the original procedure.

It is unclear what portion of the rise in hospital and physician spending is the result of growth in technological advances. One study estimated that about one-half of the increase in hospital costs can be attributed to the introduction of new medical technology.¹⁰²

Research Incentives. Incentives for private investments in research on new drugs and devices encourage new generations of technology with marginal benefits. If consumers bear little or no cost for added care and providers are paid for these services, new procedures will be prescribed whenever the

¹⁰²W.B. Schwartz, "The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief," *Journal of the American Association*, Vol. 257, January 8, 1987.

incremental benefit exceeds the cost to the patient. A private company trying to decide whether to initiate research is assured that it will have a market for any product that is even somewhat beneficial. The current system generates a demand principally for cost-increasing technologies rather than cost-reducing technologies.

Administrative Costs. Administrative costs also contribute to rising health care spending. These costs are difficult to estimate, however, since they cannot easily be separated from the costs of delivering care.

Federal, State, and private entities all participate in the financing, reimbursement, and provision of health care services. Over 600 companies offer health insurance in the U.S.,¹⁰³ for example, and their separate administrative structures and practices contribute to high administrative costs for providers.

Private insurers incur administrative costs selling and marketing policies, billing and collecting premiums, and evaluating risk. The rapid growth of managed care has also added new layers of administration for case management, utilization review programs, and provider monitoring systems.¹⁰⁴

The average insurer incurs administrative costs representing 15 to 20 percent of the premium. Administrative costs vary by group size, with smaller groups incurring significantly greater costs. Insurers' administrative charges

¹⁰³Harry L. Sutton. "Issue Paper on Administrative Costs." Prepared for the Advisory Council on Social Security, 1991.

¹⁰⁴*Ibid.*

range from 5 to 8 percent for very large groups, to 12 to 18 percent for medium size groups, to 25 to 40 percent for small groups.¹⁰⁵

Health care providers also incur administrative costs in performing various activities. Hospitals have expenses for billing, marketing, cost accounting, and institutional planning. Lack of uniform provider billing requirements by government and private insurers also adds significantly to administrative costs. Hospitals must respond to the different requests for cost and diagnostic data from each payer.

Physicians also devote a substantial portion of their gross income to office administration. Different payers may negotiate or set separate fee levels as well as different information requirements, which complicate the physician's billing system.

There has been a great deal of controversy surrounding the administrative costs of the United States' multiple-payer system. Some maintain that very large savings could be achieved by moving to a single-payer system.¹⁰⁶ Others suggest that, although there may be waste in the U.S. system, it is not associated with its pluralistic nature and that the true costs associated with single-payer systems—such as foregone benefits due to tight budget caps, patient time costs for waiting, "free riding" on other countries' contributions to pharmaceutical R&D, and the costs of collecting taxes to finance the

¹⁰⁵Hay/Huggins, Inc., Congressional Research Service, *Cost of Extending Health Insurance Coverage*, Library of Congress, 1988.

¹⁰⁶Steffie Woolhandler and David Himmelstein. "The Deteriorating Administrative Efficiency of the U.S. Health Care System," *The New England Journal of Medicine*, May 2, 1991.

system—may be at least as great as the observable overhead costs of the U.S. system.¹⁰⁷

Health Care Delivery System Factors

The health care delivery system in the U.S. is composed of a multiplicity of providers. Most Americans receive their health care from private physicians and from private nonprofit or for-profit hospitals. The Federal Government operates direct service programs including the Department of Defense system for military personnel and their dependents, the Department of Veterans' Affairs system for veterans, and the Indian Health Service for Native Americans. States and local governments also operate public hospitals and community clinics. Community health centers serve individuals who are low-income, medically indigent, young, elderly, rural, homeless, drug abusers, or persons with AIDS.

The diversity of providers making up the total delivery system meets a wide range of need, and offers most Americans access to many levels of care and kinds of services. But it also contributes to higher costs.

Maldistribution of Physicians by Specialty and Area. Maldistribution of physicians, both by specialty and geographic location, results in higher total spending for health care. Patients who do not have access to primary care physicians in their communities delay receiving care which, if it is preventive or a cost-saving early intervention, can result in an aggravated medical problem that is more expensive to treat later. In rural and inner-city areas

¹⁰⁷Patricia M. Danzon. "The Hidden Costs of Budget Constrained Health Insurance Systems," prepared for the American Enterprise Institute on Health Policy Reform, October 3-4, 1991.

where medical services are limited, people seeking care are forced to depend more heavily on hospital outpatient service systems—clinics and emergency rooms. To the extent that the costs of hospital overhead exceed those of physician office overhead, total costs are increased.

The Council heard at several public hospitals how expensive treatments could have been prevented if primary care physicians had been available to treat a patient at an earlier stage of a disease or an illness. Many patients who come to hospital emergency rooms have multiple medical problems that could have been prevented or managed with appropriate primary care.

The lack of physicians to provide prenatal care also increases total health care costs. When pregnant women do not receive prenatal care, their children often are born with low birth weights and require expensive treatments in neonatal intensive care units. The Office of Technology Assessment estimates that prevention of a low birth-weight baby by obtaining early and frequent prenatal care saves between \$14,000 and \$30,000 in total expenditures in the long term.¹⁰⁸

Only 30 to 40 percent of physicians in the U.S. choose primary care specialties (general practice, family practice, internal medicine, obstetrics and gynecology, and pediatrics).^{109 110} Several reasons are given for the tendency of American physicians to choose specialty care over primary practice. Medical school faculties are increasingly composed of subspecialists, due to government support of specialized research and the

¹⁰⁸Fahs, Marianne, *Imminent Peril: Public Health in a Declining Economy*, Twentieth Century Fund Press, 1991.

¹⁰⁹*Health United States - 1990*.

¹¹⁰*Challenges in Health Care - A Chartbook Perspective*, Robert Wood Johnson Foundation, Princeton, NJ., 1991.

growth of new technology. As medical school faculties grew more oriented toward subspecialties, the number of students choosing primary care specialties dropped.¹¹¹

Another factor contributing to choice of subspecialty practice is income. The average salary for a family practitioner is \$96,000, while that of a surgeon can exceed \$200,000 a year.¹¹² Many medical students graduate with large debts—sometimes between \$40,000 and \$80,000—and the financial obligation to repay these student loans often causes them to choose subspecialty practice over primary care.

The geographic distribution of physicians in the United States remains very uneven. Although a quarter of the population resides in rural areas, only 12 percent of physicians practice there, and even a smaller share of specialists.¹¹³

During the Council's regional hearings and site visits, providers in rural areas described several reasons why it is more difficult to attract providers. Medicare and Medicaid reimbursement rates are generally lower for rural physicians, yet a larger proportion of the elderly live in rural areas. Rural hospitals and community health centers cannot afford to pay physicians as well as hospitals in urban and suburban areas. Some physicians are reluctant to locate in isolated areas because there is less likelihood of professional interaction with colleagues. In remote areas where there is only one physician for miles, there is no one to rely on for back-up, and the job becomes a 24-hour, seven-days-a-week responsibility.

¹¹¹American Healthcare Systems Inc., *Challenges for Change*, 1991.

¹¹²*Ibid.*

¹¹³U.S. Congress, *Physician Payment Review Commission*, 1991.

Inner-city communities also have difficulties attracting and retaining physicians due to high costs of living, scarcity of housing, inadequate transportation, and concerns for safety. And because of the low-income nature of many inner-city communities, a physician cannot make enough money to pay for overhead, salary and benefits, and medical school loans.

Excess Hospital Capacity. Unused hospital capacity also contributes to higher health care costs. In 1988, there were just over one million hospital beds in the United States, with an average hospital occupancy rate of 65.9 percent. Low occupancy rates have negative effects on hospitals' operating margins, threatening their financial viability. One study reported 194,000 excess beds, mostly in small, rural, and non-teaching hospitals. The study estimated the capital costs associated with these excess beds at \$3.1 billion;¹¹⁴ some of these costs are shifted to paying customers.

When too many hospitals compete to serve the same population, total costs are increased because each hospital has a minimum level of fixed expenses to support. Arguably, some of these hospitals could be closed, merged, or converted to other uses without hurting access to acute care in the community.

Proliferation of Technology and Services. Proliferation of new technology and services is an important contributor to higher spending. Hospitals add duplicative programs, equipment, and technology to attract physicians and patients. According to one report, hospital spending on equipment increased an average of 16 percent in 1990 and is projected to rise another 10 percent in 1991.¹¹⁵

¹¹⁴American Healthcare Systems, Inc., *Challenges for Change*.

¹¹⁵Survey Identifies Trends in Equipment Acquisition." *Hospitals*, September 20, 1990.

New technologies are often viewed as a profit source without evaluating the community need for them. Diagnostic imaging systems and laboratory capacity have sometimes been purchased primarily with an eye to generating revenues. When utilization review, payment systems, and market competition fail to discourage unnecessary use of such technology and services, the result is excess costs.

Physician ownership of diagnostic facilities also contributes to more spending. A study by the Inspector General of the Department of Health and Human Services found that physicians who own or invest in laboratories order 45 percent more tests than those who do not.

Physician Education and Training. American physicians are trained to provide the best medical care available in the local conditions under which they serve and acknowledge that their first responsibility is to furnish or obtain the services that are best for the patient. When neither the patient nor the physician is at financial risk, costs are very much a secondary consideration and therapeutic choices are made largely on grounds of physician preference and training. A general lack of empirical data comparing the efficacy of alternative treatments and of consensual practice norms also makes it likely that physicians will choose treatments based on preference and experience rather than cost. This orientation contributes to higher health care spending.

Structure of the System. The current structure of the delivery system also increases health care costs. Fee-for-service medicine provides incentives for physicians to increase services to patients. Most physicians are in solo or small-group practices and are compensated directly by payers. Rudimentary managed care techniques used by most payers, such as precertification and utilization review, have not controlled the incentive to see more patients and

provide more services in the office. Discounted fees are not prevalent among physicians, as they are with hospitals and other providers.

Theoretically, the laws of supply and demand should drive prices down where there is an excess of providers, and cause providers to locate in areas where services are needed. The opposite appears to have occurred in the health care delivery system, both for physicians and hospitals. There do appear to be oversupplies of providers in some localities, yet even in these areas they furnish services of marginal value, unnecessarily raising costs. Furthermore, as previously noted, competition has not resulted in a better distribution of physician manpower by specialty or location.

Another aspect of this problem is rooted in the traditional division of functions between physicians and their assistants. Costs are increased where outmoded medical practice laws, regulations, and customs result in physicians furnishing services that could be provided at lower cost by persons with less training. Examples of such lower-cost providers include registered nurses, physician assistants, and nurse practitioners.

How the Delivery System Compensates For Other Factors. The delivery system compensates in a variety of ways for deficiencies in the financing system. Since many individuals lack access to insurance or public programs, both physicians and hospitals provide a great deal of uncompensated care to these individuals. The burden of this uncompensated care is not shared equally by all providers—public hospitals provide a greater share of uncompensated care than do other hospitals. Some of the cost of this uncompensated care is shifted to other payment sources, and some results in deficits for the provider.

The administrative complexity of eligibility determinations for public programs and the diversity of forms and procedures for reimbursement by public and private payers also create problems for the delivery system. A public hospital the Council visited, Seattle's Harborview Medical Center, employs 16 full-time equivalent employees, at a cost of over \$500,000 annually, to help eligible patients enroll in Medicaid. With over 600 private insurance companies as well as multiple public funding sources, both physicians and hospitals expend a great deal of time and money in efforts to get reimbursed.

Physicians, clinics, and hospitals also engage in activities to bridge barriers to care that exist outside the delivery system. To deal with transportation problems, community health centers operate vans to help patients keep their appointments and get to other providers such as specialists and hospitals. Some providers operate mobile clinics to take health care services directly to the homeless.

To bridge language and cultural barriers, providers employ multilingual personnel and staff who live in the community they serve. To reduce incidences of epidemiological and lifestyle-related diseases and provide early treatment and prevention services, providers conduct outreach in the community and on the streets, using health educators to identify patients and encourage them to come in for treatment. Hospitals and clinics also employ nutritionists to educate patients about lifestyle choices. Providers employ social workers to enable patients to connect with social services outside the health care system and to help them deal with other problems that affect their lifestyle choices and consequent health status.

Hospitals and medical schools conduct training and fellowship programs to provide medical students and residents with experience in primary care

specialties and in medically underserved areas. These programs try to counteract the geographic and economic factors that influence physicians to choose specialties over primary care and desirable locations over those that need their services.

Findings: Barriers to Care

External Environmental Barriers

As individuals attempt to gain access to the health care system, they face barriers external to the health care financing and delivery systems. Language, cultural differences and perceptions, lack of transportation, homelessness, the special problems of migrant workers, and even judicial decisions can all present difficulties.

The difficulty of integrating into American culture and the inability to communicate in English keep many immigrants from receiving the care they need. Patients providing medical histories or seeking educational pamphlets in multilingual formats, for example, can encounter language hurdles. Many U.S. cities contain neighborhoods where people speak little or no English, but a variety of other languages, including Polish, Cambodian, Korean, and Spanish. The situation may be complicated by the existence of several dialects within each language.

Transportation barriers are particularly acute in rural areas. Providers and consumers told the Council how rural residents often go without needed care until they can get transportation to a health care provider in a distant town. While they wait, their medical conditions sometimes worsen. In those rural areas where primary care is available, specialty care often is not. Lack of

transportation and long distances to the nearest city with appropriate specialists contribute to the health problems of rural residents.

Homelessness is another barrier blocking access to the health care system. Without ties to a provider in the community, the homeless are often unable to seek appropriate primary care and, when they do seek care, it is often in crowded emergency rooms. In addition, the homeless lack the resources to buy or store prescription drugs and common items like toothpaste, band-aids, Q-tips, or aspirin.

Migrant workers often face multiple barriers to obtaining health care. They may be homeless or live temporarily in work camps, far from their families and communities. Many speak little or no English.

Financial Barriers

The factors that drive up health care costs create financial barriers to care. As the cost of health care rises, it becomes increasingly difficult for those without insurance to purchase coverage or care.

The external factors described earlier all contribute to making care less affordable to the uninsured. When people living in poverty are unable to pay for the care they receive, health care prices increase for everyone else.

Unhealthy lifestyles and behavior—factors that people can control, but the health care system cannot—add significant costs to the health care bill. So do factors such as genetic disorders, which are beyond people's control. The judicial system—through coverage and anti-trust decisions, reimbursement requirements, and malpractice determinations—raises the overall price of care. The higher cost of transporting goods and services to remote areas raises the price to all. The health care financing and delivery system itself

has reacted to the high cost of health care, and this has erected additional barriers.

Government Laws and Regulations on Insurance. A portion of the uninsured are employed by companies who cite high cost as the primary reason they do not offer insurance. A number of governmental rules regarding insurance have effectively raised the price of insurance and exacerbated financial barriers to care.

"Anti-managed care" laws are one example of these rules. A number of States have instituted restrictions on the use of various managed care techniques such as utilization review, financial incentives to use network providers, and closed panels of preferred providers. Studies have shown that these techniques can reduce health care costs.¹¹⁶ To the extent that States prevent insurers from implementing these techniques, they make insurance less affordable and thus less accessible.

Another set of governmental rules relates to mandated benefits. The majority of States mandate that insurers include specific types of health services in any insurance plans they offer. While many of these services are indeed beneficial, they contribute to the cost of insurance. One study found that mandated benefits contribute 15 to 20 percent of the cost of health insurance premiums.¹¹⁷

A third set of rules relates to some of the unintended effects of the Federal Employee Retirement Income Security Act (ERISA) of 1974. ERISA

¹¹⁶MAPI. "Health Care Costs and Cost Containment-Getting Specific." *MAPI-Economic Report*. ER-108, Washington D.C., 1988.

¹¹⁷Health Insurance Association of America. *Mandated Benefits in Health Insurance Policies*, Washington D.C., February 15, 1991.

preempts State laws affecting employer-provided plans when the employer chooses to self-insure. Self-insured employers are exempt from State-mandated benefit laws, State taxes on insurance premiums, State assessments to finance insurance risk pools, and other regulations that tend to increase the cost of group health insurance. These exemptions have encouraged self-insurance and increased the risks and costs for remaining employer-provided plans. Further, the failure of the self-insured plans to contribute to insurance risk pools has dampened the pools' ability to reduce premiums to an affordable level.

Risk Selection. In order to maximize predictability and minimize risk, insurance companies and employers have responded to sharply rising costs by excluding certain individuals from employers' group plans. Insurers have also denied coverage to some employer groups at greater risk of incurring high medical costs. This is especially prevalent among small businesses where there are not enough employees to assure adequate spreading of risk.

Risk selection may take three forms: (1) industry or occupational exclusions, (2) medical underwriting, and (3) preexisting conditions. A number of commercial insurers do not sell insurance to industry and occupational groups which they believe represent unacceptable (i.e., high or unpredictable) risks. Factors such as high worker turnover, exposure to highly toxic substances or hazardous conditions, unusually high utilization of health services among employees, and employee lifestyle characteristics are considered in placing industry groups on "exclusion" lists. For example, dry-cleaning businesses, farmers, hair dressers, and asbestos workers are commonly found on such lists.

Medical underwriting is another means of limiting an insurer's unexpected loss exposure. Although underwriting practices vary by insurer, they

typically involve detailed analyses of the health characteristics of small-group members to determine whether the group presents an acceptable risk. Based on the risks disclosed, relevant State laws, and its own policies, the insurer has a number of options to limit its risk: it can reject the entire applicant group as uninsurable; it can accept the group, provided that one or more specific individuals is excluded from all coverage; it can accept the group and all individuals, but put specific limitations on benefits for specific individuals; or it can accept the group without special benefit limitations, but assess a higher premium than the normal group rate for covering specific individuals.

Preexisting condition exclusions (PCE) are used to reduce an insurer's expected first-year medical claims expenses. Medical care required to treat a condition that was diagnosed or treated prior to the start of coverage is generally excluded from coverage for some specified period (often six to twelve months). With the use of PCE clauses, the employer group will have low to normal first year health care utilization. However, in the second year, utilization is often significantly higher because the individuals have met the PCE waiting period requirement. This results in "churning"—i.e., small businesses find the premium no longer affordable and secure coverage through another insurer, or an insurer drops the company once the PCE is met.

The result of risk selection practices is that individuals or small groups with records of high costs and industries or members of occupations with high risks may be offered insurance at rates several times the community average or be denied coverage altogether. This can make health insurance unaffordable for many who may have the greatest need for such coverage.

Inadequate Reimbursement. Another financial barrier to care is erected when a third-party payer sets payment levels so low that providers do not participate or go out of business.

Medicaid reimbursement rates have been reported to average about 66 percent of Medicare prevailing charges.¹¹⁸ Evidence suggests that these low Medicaid reimbursement levels contribute to lower provider participation. If providers are not available to treat patients, insurance coverage is meaningless.

In hearings and site visits across the country, consumers and providers expressed concern about the low reimbursement rates of the Medicare and Medicaid programs and the barriers these low rates create. One State hospital association testified, that over the last five years, Medicaid under-reimbursements totalled \$1.4 billion. Medicaid patients remain hospitalized longer than necessary, in part because home health agencies lose money on every Medicaid patient served and it is hard to find agencies willing to care for them.

Medicare payment levels are also cited as inadequate. The American Hospital Association indicated that nearly one-half of all hospitals will incur deficits of at least 10 percent by caring for Medicare patients. Some of these hospitals in rural areas may fail financially, leaving large areas with no hospital coverage.

¹¹⁸Schwartz, D.C. Colby, and A.L. Reisinger, "Variation in Medicaid Physician Fee," *Health Affairs*, Spring, 1991.

Eligibility Determinations. While risk selection can create barriers to private insurance, the detailed Medicaid eligibility form, for those not receiving cash assistance, can create a public insurance barrier.

One county executive testified in Council hearings that he tried to fill out a Medicaid eligibility form, and after 45 minutes gave up. The application forms can be long and complex. (In some States the forms are over 20 pages in length, in part because they are consolidated applications for a wide range of programs.) Completing the forms can be time-consuming, and providing the required documentation of income, assets, and family status can be difficult. Administrative requirements—such as requiring those who have filed applications while hospitalized to come to social services offices to complete the process—can discourage completion of the enrollment process. All States impose some burden in terms of time, documentation, and process, and this is one factor that may deter persons from enrolling.

Delivery System Barriers

One barrier to care inherent in the health care delivery system is the declining public health infrastructure. Public hospitals bear a tremendous burden in caring for those who have no other source of health care, and they do not have sufficient capacity for the task. Patients who visit emergency rooms or ambulatory screening clinics may spend up to 20 hours navigating their way through the system—including triage at the emergency room, waiting to be seen by a doctor or nurse, having lab tests done, and waiting for their prescriptions to be filled. Emergency room patients often lie on beds in crowded hallways because there is either no doctor to see them or no hospital bed available.

In the 1950s and 1960s, specialized public hospitals dealt with epidemic diseases such as tuberculosis and polio. As these diseases were eradicated, the beds used for their treatment were closed and health care manpower was redeployed. The elimination of facilities equipped to deal with public health epidemics such as AIDS has resulted in barriers to care for people with epidemic diseases as well as for others waiting to enter hospitals whose emergency rooms are crowded and whose beds are filled.

A lack of facilities for the treatment of mental illness is also a barrier to care. The shift from inpatient to outpatient treatment of mental illness resulted in a decline in inpatient and residential treatment facilities of more than 50 percent between 1970 and 1982. State and county public facilities, which account for more than 44 percent of all such facilities, declined from 413,000 to 199,000 between 1970 and 1986. One unfortunate by-product of this is that one-third of all homeless people are now chronic, mentally ill patients—many of whom were cared for in hospitals such as these.

Inadequate primary care capacity in the delivery system is also a barrier to care. Services for children are one example. As school enrollments declined after the baby boomers passed through, school budget cuts forced the elimination of school nurses and school clinics. Neighborhood health centers and well-baby clinics, which flourished in the 1960s and 1970s, declined sharply in number during the late 1970s and 1980s. The result of these barriers has been a decline in health status. The percentage of young children fully immunized against childhood infectious diseases has been decreasing steadily; measles, thought to be eradicated in the early 1980s, has reappeared in epidemic form. Tuberculosis and sexually-transmitted diseases such as syphilis and hepatitis are also on the rise.

Geographic and specialty maldistribution of physicians also create barriers to care, particularly primary and prenatal care. In many inner-city and rural communities, there are few if any physicians, and patients must travel to other areas to be seen by a physician or clinic. In other areas, there may be a sufficient supply of physicians and other providers but a lack of willingness to care for low-income patients.

During a site visit to the Escondido Community Clinic, the Council heard how physician oversupply can present a barrier to care. According to the clinic director, there are many physicians in the community, but few are willing to treat low-income patients. The clinic applied for a community health center grant to care for these patients but was unsuccessful because the community was not considered a medically underserved area due to the supply of physicians.

Another barrier to care is the declining financial condition of hospitals, which may force many institutions—particularly those serving low-income communities—to close or limit services. For example, the week before the Council held its San Diego hearing, San Diego General Hospital, which served a low-income community, closed because of the inability of the community to financially support the hospital. Statistics illustrate the nature of the problem. In 1988, 65 percent of all hospitals experienced negative margins from patient revenues, and about one-third of all hospitals had negative total revenue margins. Many of these hospitals are teaching hospitals or small rural hospitals.

BARRIERS AND INCENTIVES FOR CHANGE

As explained in the preceding chapters, a lot is right about the health care delivery and income security systems in the United States. Nevertheless, there are some vulnerabilities created by both systems that need to be addressed. Today's health care reform debate contains two principal focal points: (1) the problem of access to health care for 14 percent of our population without health care coverage and (2) the sustained upward spiral of health care costs. On the income security side, the debate centers on those State employees who are not covered by either the Social Security system or another retirement system and the very old, women, and minorities who may not receive adequate protection from the Social Security system. All of these problems are readily acknowledged, and there is some agreement that they need to be addressed. The difficulty is that although there are incentives to address these problems and to make changes in both the health delivery system and the retirement income system, there are also barriers to such changes.

Incentives

In this chapter, we will first discuss the incentives for change, then the barriers that make it difficult. Incentives include the fact that escalating health care costs threaten to erode gains in productivity and real wages, that 14 percent of Americans are uninsured, that cost shifting adversely affects providers, consumers, and payers alike, that action is needed to keep the Medicare trust fund solvent, and that States are overburdened with Medicaid costs. The barriers that prevent the debate from moving forward include the following: the lack of consensus among the American public about what

should be done; the desire among providers, payers, and consumers to maximize the benefits from change while minimizing adverse affects; and finally, the lack of research and data necessary to make informed choices.

Rising Costs Threaten Economic Gains

The first incentive for change is that escalating health care costs threaten to undermine economic gains from projected increases in both real wages and U.S. competitiveness. In current dollar terms, total health care expenditures are expected to increase from nearly \$700 billion in 1990 to \$9.5 trillion in 2020. The Council's Expert Panel noted that the increase in health care spending is dramatic.

The Nation cannot continue its current consumption patterns and divert an ever-increasing share of GNP to health care expenditures. The Panel noted that the aging of the population, while not a major factor in escalating health care costs could drive savings rates lower. Housing prices will remain relatively stable, and the accumulation of financial assets of the United States through direct investments by the foreign sector and the demographics of other developed nations may make it unlikely that the United States economy can outgrow the increase in health care expenditures. In fact, it seems more likely that the United States will further decrease savings and other consumption items unless the growth in health care expenditures is significantly reduced. The bottom line is that increasing health care costs could serve to undermine United States productivity and thereby threaten America's standard of living. This in itself serves as incentive for change.

The Uninsured Are Vulnerable

Access to medical care for the uninsured is a matter of growing public concern. This concern for the uninsured is yet another incentive for change in the health care system. Over the past decade, the number of uninsured persons has increased, rising from 28.4 million persons under age 65 in 1979 to approximately 34.7 million in 1991.¹¹⁹

Research has shown that the uninsured are less likely to use health care services and more likely to be in poor health than the insured. The uninsured are more likely to receive free or charity care and are more likely to have higher out-of-pocket expenses when they do pay for services. In addition, the uninsured are more likely to be low income and unable to pay for health care, making them more likely to contribute to uncompensated care expenses and cost shifting on the part of providers.

The uninsured population is a heterogeneous group which includes (1) part-time workers, (2) those whose employers do not offer health insurance, (3) unemployed or poor persons who are not eligible for Medicaid, and (4) uninsurables or persons with high-risk conditions that insurance companies often refuse to cover. The uninsured also include dependents of employed persons (some of whom have employer-sponsored coverage), single males and childless couples who are poor but not categorically eligible for Medicaid, persons who are eligible for—but not enrolled in—Medicaid, the homeless, and the nonelderly disabled who must wait two years before they receive Medicare.

¹¹⁹ Moyer, Gene, Tabulations from the March 1991 current populations survey.

The uninsured are predominately low income; about 280 percent of the uninsured population reported family incomes below the Federal poverty standard. Almost 57 percent reported family incomes of less than 185 percent of the Federal poverty standard.¹²⁰

The lack of health insurance is not the only barrier to adequate health care access. An estimated 12 to 15 million Americans are inadequately insured. That is, their family incomes are insufficient to finance the care that their plans will not cover. The underinsured include people with coverage only for hospitalization, with strong preexisting condition exclusions, and those with no major medical benefits, which leaves them uninsured for other needed services and at risk for high out-of-pocket expenses.

Uncompensated Care and Cost Shifting

The use of services by a patient without adequate insurance coverage often results in uncompensated care. This care sets in motion a chain of events that comprises another incentive for change. Uncompensated care includes charity care, for which no payment is expected, and bad debt, for which payment is expected but not received.

Areas where providers rely extensively on public program reimbursement or have high rates of uninsured patients are experiencing hospital closings and shortages of physicians, in particular, primary care physicians.

Historically, uncompensated care has been financed through public hospitals that receive money from State and local governments. Also, hospitals that received Hill-Burton funds from the Federal government were required to

¹²⁰ Ibid.

provide charity care for 20 years. Non-patient care revenues and charitable contributions also finance some uncompensated care, and an additional portion is subsidized by third-party payers. However, as uncompensated care has grown, these historical financing mechanisms have proven to be inadequate.

In addition to the problems of uncompensated care, there are also problems with underpayment from governmental programs. The combination of uncompensated care and inadequate reimbursement has led to cost shifting. As a result, costs may be excessively high for certain payers who are paying more than their fair share. As providers try to recover lost revenues resulting from uncompensated care and the actions of the government to reduce outlays, they shift these costs to charge-based payers and their customers. This process of cost shifting is an incentive for change, both for those who feel they bear more than their fair share of the costs and for the providers who must resort to such practices to survive. In short, cost shifting serves as an incentive for change for providers, consumers, and nongovernment payers.

The Medicare Program Faces a Financial Crisis

Another incentive for change is the fact that action will be needed shortly to keep Medicare solvent. The Board of Trustees of the Federal Hospital Insurance Trust Funds indicates in the 1991 Annual Report that this Fund will be solvent for the next 14 years under certain "intermediate" assumptions. Any significant adverse deviation from these projections, however, could result in the inability of the Fund to meet its obligations much sooner than projected. The 1991 Annual Report states that, "Even though the HI Trust Fund is financially adequate based on the short range test, because of the magnitude of the projected actuarial deficit in the HI program and the high probability that the HI Trust Fund will be exhausted

shortly after the turn of the century, the Board believes that corrective action will be needed very soon in order to avoid the need for potentially precipitous changes later."

In the Report to this Council on Medicare projections, the Health Technical Panel noted that, "While we have suggested a number of improvements in projection methods, assumptions, and measures of the financial status of the Medicare program, our recommendations do not change the basic finding that Medicare faces serious financing problems, particularly early in the next century. The retirement of the baby boomers—between about 2010 and 2030—and the subsequent movement of the baby boom into advanced old age will place a growing demand on the national resources needed to finance health care for the elderly." The Panel recommended that major policy decisions about the design and financing of Medicare should be developed, not solely on annual budget negotiations, but rather from a long-term perspective that aims to design the best possible health benefit program for the elderly and disabled given the resources that Americans are willing to devote to the purpose.

As a whole, the American public favors the Medicare program. In the national survey of the Advisory Council, people were asked about their impressions of the program. Over 70 percent of the respondents expressing an opinion indicated that they had a very favorable or somewhat favorable opinion of the program.

However, most people under the age of 65 are not confident that Medicare will be there to provide health benefits when they retire. When asked this question, only 7 percent of those under age 65 said they were very confident that Medicare would be there for them.

The high support for the program coupled with the lack of confidence in its long-term reliability indicates that the impending insolvency of Medicare Trust Fund will be an incentive for some type of change in the health care system. In addition, providers and payers who depend on the Medicare program either for reimbursement or to supplement other forms of payment also have an incentive to ensure that this source of funding continues.

Medicaid Spending Is Growing Sharply

The most important source of budgetary pressure for the States has come from the dramatic growth of the Medicaid program. States provide 43 percent of Medicaid funds. In 1979, State spending on Medicaid was only \$9.7 billion. By 1981, this had grown to \$13.3 billion, and by 1991, to \$40 billion. This represents an increase of \$26.7 billion over 10 years.

This decade-long explosion in spending, averaging over 14 percent per year, has resulted from a variety of factors, including expansions of technology, increase in utilization, Federal mandates, and court decisions.

Medicaid spending is expected to continue to grow substantially even without further Federally mandated expansions of coverage. This growth reflects expected accelerations in cost in many States that have surpassed increases in reimbursements to providers and increased utilization of Medicaid services by newly eligible populations.

Medicaid burden on States has had a variety of impacts. In general, the Medicaid share of the State budgets has increased at the expense of other spending. In many cases, Medicaid expense growth has been accompanied by lost cost-of-living adjustments for the Aid to Families with Dependent Children (AFDC) population.

Even as States feel burdened by the rising costs of Medicaid, courts are directing them to provide more funding for the program. Hospitals in more than 12 States have filed suit against their State governments for failing to provide reasonable and adequate Medicaid reimbursement. In a test case, the Supreme Court upheld the right of hospitals to sue, ruling that Federal and State governments are potentially liable for inadequate funding of the cost of treating Medicaid patients. The rise in Medicaid costs and threatened court actions have produced an incentive for States to seek changes in Medicaid financing.

Barriers

Consensus Is Lacking

Although there are incentives to make modifications to the present health care system, there are also obstacles or barriers to such changes. One major barrier is the fact that there is no consensus among the American public as to what, if anything, should be changed and how such change should be effected. The National Survey indicated that 78 percent of Americans are either very satisfied or somewhat satisfied with the quality of health care they receive. In addition, those with health insurance appear to be satisfied with the quality of their health insurance coverage; 78 percent indicated that they are either very satisfied or somewhat satisfied.

In the survey, Americans were asked whether changes should be made to the health care system to meet the needs of their family or whether the current system was meeting their needs. About 61 percent indicated that the current system needs either no changes or only minor changes. When asked about five specific proposals for change, each proposal received about the same

level of support, none of it strong. No more than 14 percent of persons surveyed showed strong support for any single approach.

The Interplay of Competing Interests

Another obstacle to change is the role and responsibilities of the key parties involved in health care—government, employers, insurers, individuals, and providers. Each of these players has a unique role, and therefore a competing interest, in the financing and delivery of health services. Their roles have been established over several decades and significant reforms would require substantial changes in those roles.

Some of the same forces that are exerting pressure for changes in the system are also exerting pressure for the status quo. Each of the payors—Federal and State governments, businesses, and consumers—is struggling to meet current demands; yet each is also wary that changes to the system could mean a greater share from them.

There exists today a kind of dynamic equilibrium in the share borne by each. Tensions among these vested interests are keeping the system from changing too far in any direction so that each sector tends to maintain its position relative to others.

Evidence for this balance can be seen in the distribution of health care expenditures over time. For more than a decade, the proportion borne by each section has remained approximately constant, with none varying by more than a percentage point or two. This stability has been maintained in the face of an increase in total expenditures for supplies and services from about \$238 billion in 1980 to \$583 billion in 1989.

It is not just the rapid growth in the expenditures and the potential change in relative shares that concern each of the payers. It is also the volatile nature of the expenditures and the inability to predict from year to year the amount that a payor will be expected to provide. For example, while the private business share has remained constant between 1985 and 1989, the annual percent change in spending was 9.3, 7.7, 12.0, and 12.3, respectively.

**Percent of Expenditures for Health Services and Supplies,
By Payer: United States Selected Calendar Years 1965-89**

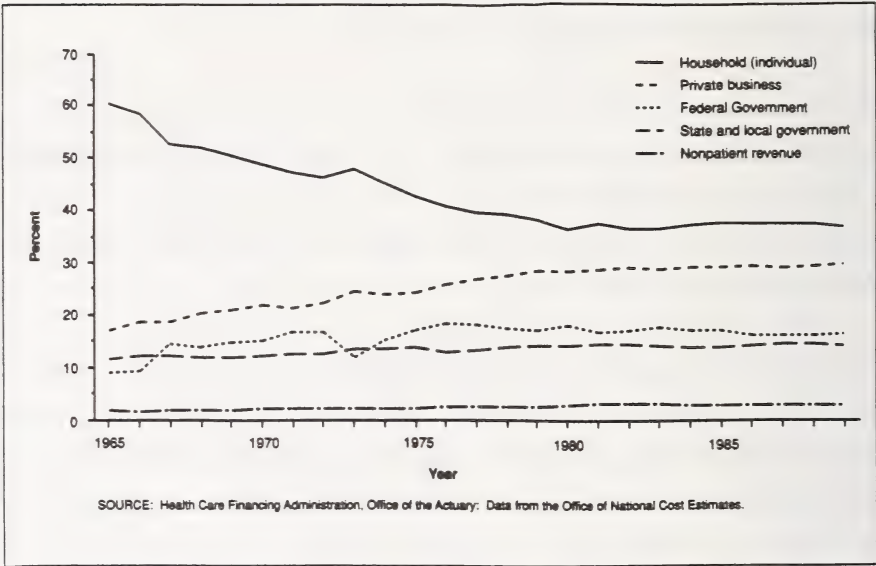


Table 2
Percent distribution of expenditures for health services and supplies, by type of payer: United States, selected calendar years 1965-89

Type of payer	1965	1967	1970	1975	1980	1985	1986	1987	1988	1989
	Percent distribution									
Total	100	100	100	100	100	100	100	100	100	100
Private	79	73	73	69	68	69	70	69	70	69
Private business	17	19	22	24	28	29	29	29	29	30
Household (individual)	61	53	49	43	37	37	38	38	37	37
Nonpatient revenue	2	2	2	2	3	3	3	3	3	3
Public	21	27	27	31	32	31	30	31	30	31
Federal Government	9	15	15	17	18	17	16	16	16	16
State and local government	12	12	12	14	14	14	14	15	14	14

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

There is uncertainty over the effects proposed reforms would produce, causing apprehension among the participants because each is concerned that: (a) the equilibrium illustrated above will be shifted, (b) the shift will occur at a pace or in a manner that it will be unable to politically or financially control, and (c) it will be stuck bearing the disproportionate burden of the outcome of reform.

Payers. Although government's share of spending has essentially not changed in nearly 20 years, health care makes up an ever-larger share of total government expenditures. For the Federal Government, it is now more than 15 percent of total spending, while it makes up more than 11 percent of State and local government expenditures. In effect, health care spending by all levels of government has increased at about the same rate as total health care spending, but much faster than other kinds of government spending. Thus, governments are under unrelenting fiscal pressure from rising health care costs and are struggling to keep these costs from crippling their ability to meet other public needs.

The States in particular feel burdened financially. The increasing costs of Medicaid provide an incentive for States to support changes in the health care system, but those costs can also create a barrier to change when State budgets are severely strained. States with such problems are understandably leery of any changes which may possibly increase costs.

The escalation of health care costs continues to be felt by both State and local governments in many different capacities. First, these governments act as employers: They have about 13 million workers covered by health insurance plans. The plans for family coverage tend to be on the comprehensive side and generally provide for employer payment of 75 to 100 percent of cost. Second, governments pay for the care received by their

wards. Wards include inmates of prisons and youth offender facilities, mental health and mental retardation patients, and children in foster care and subsidized adoption programs.

Third, health care costs appear in other programs such as schools, vocational rehabilitation, special programs to make welfare recipients ready for work, and as a part of the system provided for the homeless. Fourth, State and local governments absorb health care costs built into the prices of goods and services they buy. Fifth, governments are major health care providers themselves through: (1) public health programs, (2) community hospital services, and (3) State university hospitals, which receive substantial subsidies through education budgets. Sixth, and most importantly, State governments must pay for part of the rising costs of the Medicaid program.

Health care spending is only one of many items in the budgets of State and local governments. While health care cost increases triggered by Federally mandated Medicaid spending are draining State coffers, public pressure mounts to overhaul the Nation's educational system, and State spending on correction is also up significantly. Correctional system construction and operating costs are likely to continue squeezing State budgets for the foreseeable future. Spending on corrections is the second fastest area of growth in State expenditures, surpassed only recently by State Medicaid costs.

In its hearings the Council heard from various State officials. These officials acknowledged that they would like to see changes made in the health care delivery system. They would like to address problems such as growth in Medicaid cost and access to care for the uninsured. However, the fact that State budgets are so severely strained makes it unlikely that States will be able to initiate reforms on their own.

Employers. Employer health costs continue to increase at rates of 20 to 30 percent a year, significantly affecting labor costs and international competition. Concerned about the high cost of health benefits for employees and their families, business leaders resist changes that could potentially increase their costs.

Insurers. Insurers have used experience rating to ensure that premiums collected cover the cost of providing insurance. In large businesses with many employees, it matters little if some employees have serious medical conditions, since the financial risk of such employees can be spread among the many healthy workers. However, for small businesses with few employees, insurance companies cannot collect enough in premiums to pay the claims of those who are sick. Therefore the rules for insuring workers in small businesses are more rigorous. Insurers are wary of any changes that could inhibit their ability to cover costs with premiums.

Employees. Although employees now assume more responsibility for health benefits coverage through copayments, deductibles, and coverage choices, they still do not pay the full cost of health benefit coverage. Subsidization is something they have come to expect. Americans want to see the high quality of health care they receive continue, but they do not want to be faced with higher costs.

Providers. As payers seek to restrain costs and insurers seek the better predict costs, health care providers and suppliers seek to protect their incomes and practice styles. Health care providers and suppliers are experiencing great difficulty in delivering quality services in a cost-constrained, regulated market environment and can be expected to resist any move that might exacerbate these problems.

Hospitals face enormous cost pressures resulting from the efforts of both government and business to keep their own costs from continuing to rise. The imposition of DRGs in the Medicare program and negotiation of preferred provider rates by private payers requires hospitals to become more efficient in order to maintain their financial viability. At the same time, they must cover the costs of uncompensated care provided to the uninsured and make up for payments from Medicare and Medicaid that do not cover their full costs.

In seeking to safeguard their vested interests, hospitals can be expected to resist reform proposals that would stimulate competition with hospitals, further erode in-patient days or in-patient or out-patient payment rates, limit the services hospitals could offer, encroach on tax advantages or profit-producing business arrangements, hamper cross-subsidy arrangements without substituting what hospitals would consider adequate direct payments, or give additional strength to those seeking to second-guess medical necessity and deny payments.

Dramatic changes in the practice of medicine threaten physicians' incomes, their traditional doctor/patient relationships, and their ability to practice medicine as they desire. Physicians believe that intrusive actions by third-party payers and the government jeopardize quality because time is taken from patient care and crucial treatments are withheld due to cost constraints. The concerns of the medical profession over reforms that might erode what they see as appropriate scientific standards, autonomy of clinical judgment, and practice income will produce profession-oriented resistance.

Pharmaceutical and medical supply companies have a very large stake in the shape of health reform. An expanding health sector is vital to their profitability. Many of their products add system costs through the costs of

the products themselves or the increasing numbers of well-trained health workers necessary to use them. Some enhance productivity of current providers. All will certainly wish to maximize their markets, minimize restrictive (or market-narrowing) regulation, seek competitive advantage, and obtain protections against losses. Thus, reform proposals that would directly or indirectly limit utilization (through practice standards or utilization review, for example) or would broaden competition through such measures as favoring generic drugs would be resisted.

All of the players have an interest in preserving certain facets of the health care delivery system. For example, consumers want to ensure that the coverage they receive is not eroded, and doctors would like to preserve their autonomy. Hospitals faced with deteriorating financial conditions would resist moves to cut reimbursement rates, as would physicians.

More Information Is Needed

Another barrier to health system change is the lack of research and data needed to make informed choices about policy decisions. There is clearly much to be learned about how the dynamics of social policy interact with the economy and what that means for future economic growth. Additional meaningful information about these interactions can only benefit our society through more informed decisionmaking.

A fundamental requirement for policy decisions is data of good quality, scope, and relevance. In today's environment of instant policy analysis, good data must be coupled with tools that can provide the policymaker with reliable and understandable information on the choices that are available. The importance of investing in these foundations of good policy analysis cannot be overstated. Today's policymakers have benefited from past

investments. The complex social policy alternatives facing decisionmakers have been substantially refined over time because of the investments made in data collection, socioeconomic research, and macro and micro simulation and forecasting techniques. Continued investment in the foundation of informed social policy decisionmaking becomes more critical as social programs continue to command more of society's resources.

RECOMMENDATIONS OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

Social Security Recommendations

The Council was pleased by its findings which indicate both the fiscal solvency and public acceptance of the Social Security program. Although the Council does make the following recommendations for further examination of specific Social Security-related issues, on balance, no large-scale changes are needed to the program at this time. For this reason, the Council has chosen to concentrate the majority of its recommendations on the health care delivery and financing systems, which merit neither that level of fiscal solvency nor public confidence.

The Economy and Social Security

The Council reaffirms its Interim Report finding that persistent large deficits in the Federal budget impede the Nation's ability to invest in the future productive capacity of the economy. The Council also reaffirms its recommendations on the relationship of the Social Security Trust Funds to Federal budget policy. Those recommendations follow.

Deficit Reduction. It is important to move from large Federal deficits to achieve surpluses in the total Federal budget, providing for a strong economy when the baby-boom generation retires. To meet this goal, the Council supports removing Social Security from the calculation of deficit reduction targets to focus public attention on the importance of reducing the deficit in the rest of the budget.

The Council supports the continuation of partial reserve financing of OASDI and, at the same time, urges a major reduction in the deficit of the non-Social Security portion of the Federal budget.

Trust Fund Revenues. The Council recommends that no action be taken now to reduce revenues to the OASDI Trust Funds.

Reserve Investment Policy. The current policy of investing OASDI reserves in interest-bearing U.S. Treasury securities, with principal and interest guaranteed by the U.S. Government, should be continued.

Financial Status of the Trust Funds

The Council finds that the Social Security system is soundly financed over both the near term (the next decade) and over the next 50 years.

Scope of Coverage and Adequacy of Benefits

The Council makes the following Social Security recommendations:

Coverage of State and Local Employees. Social Security coverage should be extended on a mandatory basis to all newly-hired State and local employees.

Women and Minorities. Structures should be created to examine a myriad of Social Security program issues related to women, minorities, and low-income individuals. Task forces on each of these population segments should be convened by the Commissioner of Social Security.

Technical Panels. A mechanism should be established to ensure periodic reassessments by expert technical panels of the soundness of the long-range assumptions in the Social Security and Medicare programs and the continuation of the work begun by the Expert Panel on the Future of Income Security and Health Care Financing.

Health Care Recommendations

An exhaustive review of the significant and unsustainable weaknesses in health care delivery and financing, coupled with long-range economic forecasts and the benefit of months of public hearings and outreach, led the Council to conclude that the sustained financial security of American families rests to a substantial degree upon the extent to which the country reforms its entire approach to the consumption, delivery, and financing of health care in the United States. Due to the inequities in our current health care financing and delivery systems and the unacceptable rate of growth in costs, the Council has chosen to concentrate the weight of its recommendations on health care. The Council was guided in these recommendations by a dedication to the proposition that health care is of extreme and immediate importance to the financial security of citizens individually, families, and the country as a whole.

The Council identified four urgent needs in health care, and has chosen to group its recommendations according to these fundamental concerns; these are interactive recommendations, and many will reduce costs as well as increase care and improve access to care. These needs are:

- Improving access to health care for millions of Americans;

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- Significantly reducing the rate of growth in health care costs and increasing the rate of growth in the general economy;
 - Fundamentally reforming many of the basic institutions involved in the delivery and financing of health care; and
 - Fully involving the American people, without whose support even the most rational plan cannot be enacted, in the development of America's 21st century health care system.

In the budgetary and economic climate of the early 1990s, no reforms will be pursued without development of Federal cost estimates and identification of appropriate financing sources. Therefore, the Council had independent cost estimates proposed for the recommendations it makes and offers a suggested list of offsets which could be used to fund them. Detailed explanations of the proposals are found in Appendix B, their cost estimates can be found in Appendix C, and the offsets for the proposals are found in this section.

Improving Access to Care

The Council's recommendations to improve access and institutional efficiency are basic reforms that can serve as a foundation for future financing reform. These recommendations make clear that the Council believes that access to care and health status should be the primary goal and that access to insurance, whether public or private, is not necessarily sufficient to achieve access to care. For example, the Council has found that in inner cities or rural areas, direct care approaches may be most appropriate for these vulnerable populations. Therefore, the Council's recommendations move to correct weaknesses in both the health care delivery as well as financing systems.

Health Care for Children—School-Based Clinics. The Council believes that providing access to health care for our Nation's children is of immediate and critical importance and lies at the very foundation of any health care structural reform. Statistics more than bear this out. For example, in the State of California, even with the improvements gained through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) expansion of Medicaid, only 33% of children ages newborn through four who were continuously enrolled in Medicaid since birth had seen a doctor.

Accordingly, the Council recommends enactment of a "School-Based Health Services and Referral Act" which would establish a Federal grant program, administered by the Secretary of Health and Human Services, to reimburse States for their administrative expenditures in establishing and operating health clinics in public elementary schools or in locations reasonably adjacent to public or private elementary schools and to share with States the cost of providing clinical services to children from low-income families. The clinics would offer all pre-school and elementary school children preventive and primary health care services and basic dental care. In addition to providing services to Medicaid eligibles, the clinics would offer care to other students on a sliding fee scale depending on the family ability to pay. A Federal grant program would assist States with 75 percent of their expenses in providing these services to families with incomes up to 185 percent of poverty.

School-Based Major Medical Insurance. This complementary program is proposed to assist the States, through school districts, in offering a voluntary, supplemental, low-cost insurance product limited to paying the costs of major medical expenses to all pre-school and elementary school children registered at the schools of the State. The insurance would remain available until a participant attained age 22, regardless of whether the participant were still in

school. The Federal Government would reimburse the States, within an annual aggregate Federal program cost of \$500 million, for 75 percent of their expenses in providing subsidized insurance to students with family incomes up to 185 percent of poverty. The development of group health insurance coverage is currently being tested in Volusia County, Florida, supported by the Office of Maternal and Child Health and the Robert Wood Johnson Foundation.

Increasing Access to Primary Care. While schools can be used to expand health care access for children, migrant and community health centers can be the vehicle to reach an estimated 12 million Americans who live in areas without primary care providers. The Council recommends that new Federal funding be provided to establish an additional 250 community and migrant health centers, to be located in areas with high concentrations of underserved target populations such as high-risk pregnant women or the homeless. The Council also recommends that there be established 20 "R.E.A.C.H." (Rural Emergency Access to Community Health) centers to provide emergency access to community health services in rural areas.

In addition, the Council strongly recommends legislation to authorize the Secretary to revise the priorities of the National Health Service Corps program to place more emphasis on ensuring that primary care personnel serve these target populations, through a restructuring of grants, loan forgiveness programs, and service rotations which provide incentives for efficient practice in underserved areas.

The Council strongly recommends an increase of \$100 million for the budget of the National Health Service Corps to fund these activities.

Reducing Infant Mortality. Each year in the United States, nearly 40,000 infants die before their first birthdays. The U.S. infant mortality rate of 9.1 deaths per 1,000 is twice as high for blacks as it is for whites and ranks an incredible 24th among industrialized Nations. Our most vulnerable babies will have a better chance in life if barriers to improved prenatal and perinatal care are eliminated; informational outreach is improved; better transportation and child care are provided to enable mothers to receive prenatal care; formidable eligibility and paperwork requirements for public programs are simplified; and currently overworked and understaffed clinics are improved so as to make services more readily accessible.

The Council recommends legislation to integrate the Women, Infants and Children (WIC) program with the Maternal and Child Health Block Grant program under the administration of the Department of Health and Human Services. This consolidated program, emphasizing good nutrition accompanying good health care, would offer a simplified application form, with presumptive eligibility. It would use publicly financed providers (such as community health centers) as a single location to determine eligibility for all programs pertinent to infant health, and would support outreach activities to publicize the availability of services, transportation, and child care.

Promoting Employer-Based Health Insurance. The Council recommends a four-pronged strategy to encourage the provision of health insurance in the workplace:

Model State Law. The Secretary of Health and Human Services would develop and publish a model State law applying to group health benefit plans covering employers of two to 50 employees. These plans would be required to meet a number of conditions governing the exclusion of employees for pre-existing conditions, renewability, the use of medical underwriting,

availability, denial because of risk, waiting periods for coverage, premium variations among groups, and annual premium increases.

To permit small employers to offer such plans at low cost, such a model would call for insurers to establish risk pools which could be funded by a number of options, including State-assessed contributions. In the case insurers chose not to establish such a pooling arrangement, the State would establish a reinsurance pool in which all insurers within the State would participate. If a State does not adopt the model legislation within three years of the Secretary's promulgation, the standards for small employer policies would go into effect in that State as Federal standards.

Disallowance of State-Mandated Benefits for Small-Employer Core Health Benefit Plans. Health insurers and other organizations offering health benefit plans to employers would be relieved from State requirements that small-employer policies limited to core benefits contain specified additional benefits and cover services by designated categories of health care providers.

Preemption of State Laws Limiting the Use of Managed Care in Health Benefit Plans. The proposal would free health care insurers from State limitations on the use of managed care, while safeguarding patient access through a mechanism requiring DHHS to establish alternative State-imposed limits. State laws would cease to apply that currently inhibit carriers from contracting with providers, that restrict the carriers' ability to negotiate with providers regarding reimbursement, and that restrict the inclusion of financial incentives to patients in managed care plans.

Improving the Portability of Private Health Insurance. Tax law changes would induce health insurers to extend employer-based health coverage to new employees with a history of recent prior health coverage without

imposing restrictions on pre-existing health conditions, claims experience, receipt of health care, medical history, or lack of evidence of insurability.

Health Insurance for the Self-Employed. The Council recommends that the Treasury Department review the deductibility of health insurance premiums paid by the self-employed with a view to proposing a tax law change that would place the self-employed on the same footing as employees with regard to the tax treatment of health insurance premiums.

Reducing Health Care Costs and Increasing GNP Growth

Health care is consuming 15 percent of the Federal budget, 20 percent of the States' budgets, and 25 percent of business profits. At the same time, the Medicare trust funds face insolvency and Medicaid costs are burgeoning. The Council believes the most urgent task in health care reform is to effect a real reduction in health care expenditures in both the public and private sectors. At the same time, maintenance of quality care, strong prevention efforts, and individual commitment to healthier lifestyles are aspects which must be incorporated into any reform proposal.

Good medical care and strong prevention efforts will make significant contributions to reducing costs, but the Council is equally convinced that the Nation must reform significantly many of its basic health care delivery and financing institutions if costs are to be reduced to the extent necessary. Equally important is the size of the economy; to the extent the productive capacity of the economy is increased, the Nation can better afford its health care costs.

Commitment to Reduce the Federal Deficit to Improve the Productive Capacity of the Economy. A strong economy is the only solid basis upon

which health care benefits can be financed, whether provided by the private or public sector. In order to sustain sufficient economic growth, we must increase the productive capacity of our economy and compete successfully in the global marketplace. This can be achieved only through a firm commitment to education, training, human resource development, and capital investment in plant and equipment.

The Council has observed previously that the fiscal policies of the U.S. Government are jeopardizing this Nation's ability to invest in the productive capacity of the economy. Accordingly, the Council underscores the importance of the U.S. Government in moving from large deficits to achieve the surpluses necessary for the economy to support a level of increased health expenditures during the next decades. The Council believes this action to be critical even if measures are implemented to reduce substantially the rate of growth in public and private health care expenditures.

Task Force on Investment in Human Resources. The Council recommends that the President establish a cabinet-level Interagency Task Force on Investment in Human Resources which would be charged with developing a comprehensive, interagency strategy to improve investment in American human resources and improve productivity and competitiveness. This task force would appraise the effects that current trends in education, housing, nutrition, and alcohol and drug abuse have on the health status of the work force and its productivity. The task force would then develop a five-year strategy with goals and objectives detailing how Federal agencies can respond to the problems identified.

Medical Treatment Outcomes Information. Good quality medical care is the basis upon which all cost reduction proposals must rest. The Council recommends that the Agency for Health Care Policy and Research focus its

efforts on developing a system that would produce comprehensive reports on the performance of local and regional health care markets. These reports could be used to address flaws in three critical policy areas: information, finance, and manpower. Reports could include information on the location of local and regional market areas, the per capita allocation of hospital beds, physicians, and other manpower in each market, expenditure, reimbursement, and transfer payments between regional and local markets, utilization rates, and certain outcomes.

Alternative Procedure to Adjudicate Malpractice Claims. This two-part proposal was developed to provide a more efficient alternative to the current malpractice system.

The Federal Beneficiary Malpractice Adjudication Act is proposed to establish a national administrative tribunal which would hear malpractice claims asserted by individuals entitled to receive or be reimbursed for health care from the Federal Government. The tribunal would award a prevailing claimant compensation for economic losses resulting from physical harm caused by negligent treatment, reasonable attorney fees, and not-to-exceed-\$200,000 per claimant in non-economic damages. This would be the exclusive remedy available to Federal beneficiaries under State and Federal law. The proposal would also require the Agency for Health Care Policy and Research to develop practice parameters, i.e., formal guidance to physicians and other health professionals on the best contemporary health care practice. The parameters would be used by the tribunal in evaluating claims of malpractice under the program.

The Model State Malpractice Adjudication Act is also proposed as a parallel to the Federal act. It would establish a State administrative adjudication mechanism to hear malpractice claims enabling claimants to seek this

exclusive remedy as a prompt resolution of claims made under State jurisdiction. A prevailing claimant would be awarded compensation for economic losses resulting from physical harm caused by negligent treatment and reasonable attorney fees. The proposal would continue to allow the award of non-economic damages, with a limit of \$200,000 per claimant, but would abolish derivative damages such as a wife's right to damages for loss of consortium. Guidelines for use in evaluating claims would be developed by a State Advisory Council on Standards of Health Care.

If a State does not adopt the model act within five years of promulgation and Congress has enacted the Federal law, at the option of either part, the Federal act would be opened to all malpractice claims arising in the State.

Containing Medicare Costs through Selective Contracting. One deficiency in the present health care delivery system is that incentives are not provided for patients to utilize facilities which are proven to provide specific services in a high-quality, cost-efficient manner. The Council proposes instituting a system whereby Medicare reimburses a provider for the costs of performing a designated medical or surgical procedure—a procedure typified by its high cost to the program—only if Medicare has first approved the provider for the performance of the procedure. The Health Care Financing Administration, in cooperation with the Social Security Administration, would design and implement administrative arrangements to inform patients of the existence of these approved providers and put patients in contact with provider networks from which information can be obtained as to available services.

Establishing Centers of Excellence. A companion to the selective contracting proposal is this recommendation that Medicare reimburse health care providers for the costs of performing major surgical procedures for life-

threatening disabling conditions only if those procedures are performed in "Centers of Excellence," facilities which meet rigorous criteria for quality and efficiency. This recommendation would channel patients to facilities successful in performing certain procedures, discourage such procedures at less-efficient facilities, and improve the cost-efficiency of their delivery. Since one consequence of the proposal would be to reduce the number of facilities at which designated procedures would be performed, the Council also proposes to reimburse Medicare beneficiaries for the cost of travel to the facility.

Promoting Healthy Lifestyles. Despite earnest public and private efforts aimed at encouraging healthier lifestyles, it is clear to the Council that the United States could reduce immeasurably its health expenditures through a number of major strategies aimed at increasing the focus on health promotion and disability prevention. According to the Department of Health and Human Service's *Healthy People 2000*, "tobacco is the most important preventable cause of death in the United States, accounting for one of every six deaths, or approximately 390,000 deaths annually." In addition, as the Department of Health and Human Services noted, tobacco use poses a major risk factor for a host of serious diseases, and in children is highly correlated with drug and alcohol abuse.

The Council supports the objectives of the Secretary's *Healthy People 2000* report, but urges action to achieve faster progress toward its goals. The Council recommends prohibiting all forms of advertising for tobacco and tobacco products and banning the sale of cigarettes from vending machines. The Council also recommends the phase-out of all tobacco subsidies, under a program that would offer loans and other short-term assistance to farmers in order to facilitate conversion to other crops. A final component of this

proposal would establish a statutory foundation to develop and implement programs to encourage healthy lifestyle choices.

President's Council on Fitness for the Second Fifty Years. To accommodate the changing needs of an increasingly older society, it is clear to the Council that the government must promote health throughout life, prevent the ill from becoming disabled, and help the disabled function in today's world. The Council proposes that the President establish a President's Council on Fitness for the Second Fifty Years modeled on the President's Council on Physical Fitness and Sports. This panel would promote activities intended to assist the elderly in maintaining their physical and mental fitness in the face of increasing age.

Research to Foster Independent Living. The Council recommends that there be established within the National Institute on Aging a Center for Fostering Independent Living which would conduct and support applied research into the means—social and scientific—of fostering independent living among persons suffering an impairment in ability to perform daily activities. The Center would work toward developing improved methods of assessing the ability of impaired individuals to function in a noninstitutional setting, would undertake an evaluation of the effectiveness of existing rehabilitative therapies, and conduct research to treat or correct urinary incontinence. The Council envisions that the Center would also support ways to optimize living arrangements for the elderly and, in consultation with the Food and Drug Administration, aid in efforts to develop and make available drugs and devices having special relevance to the aged.

Providing Drug and Alcohol Abuse Prevention, Education, and Treatment for Preschool and Elementary School Children. The Council believes that the Surgeon General of the United States should develop a

program to provide prevention, education, and, where appropriate, treatment for alcohol abuse and drug abuse affecting pre-school and elementary school children. The program should include the development of educational materials that parents and teachers can use to teach pre-school and elementary school children to avoid alcohol and drug abuse, efforts to encourage producers of children's television programming to include anti-alcohol and drug-abuse themes and messages in children's programs, and public service announcements and other public education efforts directed specifically at children.

A Public Education Campaign on Prevention. The Council also suggests that the Surgeon General conduct a massive three-year campaign of public education on the prevention of disease through changes in personal behavior and the use of preventive care and screening. The campaign would involve a coordinated effort using the broadcast and print media including public service announcements, outreach to community groups, and cooperative ventures with businesses. The campaign would also involve schools through the design of curricula for use in health education classes and presentations on preventive health issues.

Model Courses on Family Financial Management and Long-Term Planning. The Secretary of Health and Human Services, in conjunction with the Secretary of Education, should develop and disseminate to States model secondary school course units and materials for family financial management and long-term planning to meet major expenses. Such teaching materials would include information on health care, including major medical expenses, education, purchase of a home, child care, unemployment, and retirement. Course units would include elements on credit card and checking account management, the availability of pertinent Federal and State programs (e.g.,

Federal student loan guaranties, State unemployment insurance benefits), and tax planning (e.g., IRA and Keogh plans).

Reform of Health Care Institutions

Reducing Health Claims Paperwork. The Council recommends that the Secretary convene an Advisory Council on Health Claim Standardization to consist of 15 individuals widely representative of the health care community. Within two years of its appointment, the Council would recommend to the Secretary a uniform health claim reimbursement form for hospital services that would include all charges arising from an individual's hospitalization, including program eligibility and insurance coverage information. This would be the only form that HCFA or any private health care insurer in the United States would use for hospital or physician claims reimbursement. The Health Claim Standardization Council would also report on the computerization of health claim billing, i.e., the use of electronic means to transmit billing information from hospitals and physicians to insurers and HCFA.

Technology Assessment and Data Pooling. The twin concerns that unnecessary care leads to rising health care costs and that this country's outstanding record for quality care could still be improved fuel a growing interest in better information on what constitutes appropriate and cost-effective medical practice. The Council believes this movement can, and must, transform the institution of the practice of medicine.

The Council recommends that the Secretary of Health and Human Services establish an Advisory Group on Technology Assessment Data, broadly representative of the public and private sectors, to promote assessment of technology through the use of a wider linkage of information. The advisory

group would develop standards to be used in collecting and maintaining such information and would also establish uniform definitions of information to be collected and used in describing such components as a patient's clinical and functional status, common information reporting formats, and standards to ensure the security, accuracy, and appropriate maintenance of the system.

The Council also recommends that the Attorney General and the Secretary of Health and Human Services jointly develop proposals for legislation to amend the antitrust laws to permit hospitals and insurance companies, in consultation with the medical profession, to compare and pool data for the purpose of developing improved methods of technology assessment and medical evaluation.

The Medical Directive and Proxy Act. Terminal illness is a suffering few, if any, can truly understand, and is only exacerbated by our system's indifference to care and insistence on cure. The Council has drafted a series of recommendations to examine ways in which this situation can be reversed. The Council recommends that the President convene a statutory conference—drawing individuals from the communities of patients, clergy, ethicists, medical professionals, and government—to foster a public discussion of this sensitive issue and develop necessary reforms to encourage individuals facing terminal illness to self-direct their care.

In addition, the Council proposes that legislation be developed to establish a registry within the Department of Health and Human Services to (1) provide to all participating physicians a "Medical Directive and Proxy Designation" form, (2) inform each Medicare eligible, at the physician's office, about the availability of that form, and (3) encourage the individual to seek the physician's interpretation of the form. By filing an executed form with the registry, any individual could designate the acceptability of specified life-

prolonging medical procedures in the event of incapacitating medical situations or give a proxy for decisions on the cessation of life-sustaining treatments.

As indicated above, the registry would be available for all citizens who choose to file a Medical Directive and Proxy Designation form and pay the required fee. However, at the discretion of the Secretary of Health and Human Services, a State could enter into an arrangement with the registry under which the State would pay the registry fees for its citizens, reimburse the registry for special arrangements, e.g., notifying physicians and citizens of the State of the availability of the form, making a statewide distribution of the form to physicians, and providing the State with computer access to the registry data base (subject to appropriate safeguards of individual privacy).

Hospital Mergers and Joint Ventures. A recent study¹²¹ indicated that "the Justice Department market concentration standards are likely to exempt virtually no hospital mergers from scrutiny, although mounting evidence documents significant potential savings in increased efficiencies from hospital mergers." The Council recommends that the Attorney General develop legislation to amend the antitrust laws and permit certain mergers of two hospitals in the same community. The proposed legislation should include criteria relating to the length of time each hospital has served the community, the occupancy rates and relative financial condition of each hospital, and the willingness of each to engage in the merger.

The Council also proposes that the Attorney General and the Secretary of Health and Human Services jointly develop legislative proposals to permit

¹²¹ McCann, Robert W. and William G. Kopit, *The Government's Hospital Merger Policy*, January 2, 1990.

two hospitals in the same community, in limited cases, to enter into a joint venture to provide hospital services at one facility and health-related services (such as long-term or outpatient care) at the other.

Facilitating the Dissemination and Use by Physicians of Effectiveness Research and Medical Practice Guidelines. The Council suggests that the Department of Health and Human Services develop a model curriculum and materials to train both fourth-year medical students and practicing physicians in subjects essential to the conduct and use of effectiveness research and the development of practice guidelines, e.g., epidemiology, biostatistics, research methodology, and technology. It is also recommended that a grant program be enacted to support the development of computer-assisted programs including model teaching units to help physicians determine the most efficient and effective methods of diagnosis, treatment, and case management while minimizing the use of unnecessary tests and treatments.

Merging Medicare Parts A and B. The Council endorses this recommendation of its Health Technical Panel, which described the evolution of the hospital's role in health care since Medicare's enactment in 1965 and noted the outmoded distinction between parts A and B with recent emphasis on care outside the hospital setting. The Council envisions that the administration of the two parts of Medicare would be merged, with funding derived from the existing sources of payroll taxes, general revenues, and premiums. Eligibility and financing would not change. HCFA would develop the means of maintaining the integrity of the relative share of program costs in determining the part B premium.

Achieving Support from the American People

For well over a decade, the rate of health care growth has consistently outstripped that of average earnings. The Nation's health care costs have increased at triple the rate of growth of the general economy growth, an imbalance which cannot continue without threatening the very economy upon which the security of all Americans rests.

While the Council's thoughts mirrored the Nation's lack of consensus on how to assure access to care for all Americans while controlling costs and improving quality, this Panel unanimously agrees that immediate and dramatic steps toward reform are essential. We believe that the window of opportunity for reform is open now and that such reform must be completed by the end of the century.

The Council's National Survey on Social Security and Health Care underscored the difficulty in the reform process, revealing that our citizens hope to maximize personal preferences, to retain the broadest choice of providers, the most comprehensive menu of services available on demand, and the highest quality of care—all while minimizing out-of-pocket costs.

The clamor for services, perhaps encouraged by an insurance system which insulates patients from the impact of costs, directly conflicts with preferences for low costs—a conflict at the heart of today's health care debate. Americans have come to expect the benefits of a health care financing and delivery system in which the unlimited development and spread of technology promise cures—or at least the fullest and most advanced possible treatments—for all ills. These expectations must be reconciled with the urgent need to slow the current fiscally and socially unsustainable rate of growth in health care expenditures.

The Council fully recognizes that divisions over the best long-range policy course must be resolved through our democratic political process, which reflects the heterogeneity and independence of the American people. This process has already fostered across the Nation growing debate and such positive signs of initiative as Colorado Speaks Out on Health, California Health Decisions, Vermont Ethics Network, and town meetings held in Oregon.

The Council recommends an aggressive, strategic Federal commitment to comprehensive health care reform wherever the political will to achieve it appears. To this end, the Council recommends that the Federal Government dedicate \$3 billion and create an oversight commission to ensure immediate enactment of representative samples from the full range of structural reforms described in Appendix D, with at least one in each State.

The political will to initiate comprehensive reform emerged in Hawaii in the early 1970s, and more recently in Oregon. Such actions may occur in determined States and communities throughout the Nation.

It is important to set out the fact that not one of the variety of health care reforms, structural overhauls, and systemic reorganizations proposed by scholars, legislators, and members of this Council is based in real program experience in the interactive, mobile, and dynamic U.S. community, where the face of the nation changes daily, people and jobs migrate on demand, the transition to an information-based economy moves with fits, starts, and dislocations, and the problems of urban and rural access to health care could not possibly pose unsurpassably stark contrasts.

Cost estimates for proposed reforms being discussed today are based on mathematical models using varying interpretations of diverse findings. A

particular problem arises with respect to future orientation such as the long-term impact on the cost, access, and quality of services provided. Most policy proposals consistently defined the problems of health care financing and delivery in contemporary terms based on current statistics. This orientation can lead to both definition of solutions and evaluation of their adequacy in terms of today's environment. However, any substantial reform is unlikely to be initiated and implemented immediately, is likely to be phased in over several years, and is likely to have a pervasive effect over an ensuing 20-year period. We must thus ground evaluation of the effectiveness of proposed solutions in economic and social circumstances likely to evolve during the coming 30 years. The criteria used in any such evaluation must address each troubled component of today's system as well as the need to defuse the economic threat that rising costs pose to the future of our economy.

The stakes inherent in health care reform—its impact on the lives, jobs, and futures of millions of Americans—make the costs of error unusually dire. The majority of this Council thus concludes that the responsible course is to allow the Nation to evaluate in a national context all individual reforms that achieve community or State support.

The Council has identified a series of prototypes that it believes warrant demonstration, recognizing that the country may, ultimately, adopt a combination of more than one prototype. The prototypes would be implemented by individual States who wish to participate. They would apply for necessary waivers of legislation such as the Medicaid Act. For prototypes that entail testing the impact of Federal tax codes changes, the States would receive funding to support tax incentives or to modify State tax codes to simulate the program.

The States have been fertile testing grounds for new ideas. Some have been implemented, while others are in the planning stage. A considerable body of Federal law was first demonstrated by the States. For example, the New Jersey experience in the 1970s with paying hospitals on the basis of Diagnosis Related Groups (DRGs) was instrumental in Medicare's adopting this system. State demonstrations in other sectors such as welfare reform and low-income housing have ultimately become Federal policy.

The following are other illustrations of the willingness and ability of the States to undertake large-scale demonstrations:

- Hawaii mandated in 1975 that employers provide health insurance to full-time employees and provides subsidies for low-wage workers and persons not eligible for Medicaid. Of all the States, it has come the closest to achieving universal access to coverage. ERISA restrictions currently preclude other States from passing similar legislation.
- Oregon has passed comprehensive legislation recognizing both the inequities in coverage and the unaffordable cost of meeting all demands for services under a universal scheme. The State has sought Medicaid waivers to allow it to cover everyone below the poverty line. It has also defined a minimum benefit package by prioritizing services and proposes not to pay for (nor to incorporate in any private sector mandate) services judged to be of low priority. The combination of tax incentives and penalties and a high-risk pool would achieve near-universal coverage. Oregon has also engaged in a process of both provider and citizen participation that, along with the prioritization process, has attracted national and international attention.

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- New York is considering a proposal that borrows some elements of the Canadian health system while retaining a mixed public and private system. Under the UNY*Care proposal, payment rates for hospital, physician, and other health services would be controlled to keep aggregate outlays within an acceptable range. To reduce administrative costs, the State would operate a single claims processing and payment system for all private and public programs. Private insurers would continue to provide coverage to individuals not eligible for public programs, but their role would change dramatically: they would focus on efforts to prevent over-utilization. UNY*Care would also provide universal health coverage through an expansion of Medicaid and an employer mandate.
 - Maryland, faced with unexpected increases in costs in its "all-payer" hospital system, is exploring different methods of using the tax system—including a tax credit approach—to effect comprehensive reform.

Prototype Comprehensive Reforms

The specific prototypes that the Council proposes be tested, which are described only in very broad terms, follow. (Note: these proposals are not in any specific order.)

Insurance Market Reform

- Carriers selling to small groups, defined as having fewer than 50 employees, would face a series of regulations designed to assure the availability of coverage to these firms. The regulations would address

such matters as limitations in pre-existing condition exclusions and in premium-setting practices. A reinsurance mechanism would be established to cover high-risk groups and would be funded by an assessment on small group insurance policies.

- The self-employed would be able to deduct 100 percent of the cost of health insurance rather than 25 percent as at present, and small employers (fewer than 25 employees) would be provided a refundable tax credit for employee health benefit costs in excess of 5 percent of gross revenues.
- State Medicaid programs would be expanded to cover all persons living below poverty regardless of categorical eligibility, and individuals between 100 and 150 percent of poverty could purchase coverage on an income-related scale.

The All Payer Model

- Employers would be required to cover all employees and dependents working 17.5 hours or more per week.
- A public program would be established to cover nonworkers that would subsume Medicaid. The premium and cost sharing would be subsidized for persons below 200 percent of poverty.
- Statewide expenditure targets would be established for all mandated expenditures. In order to facilitate the administration of the provision, only a limited number of carriers would be selected competitively, and they would be the only ones allowed to offer mandated coverage in any given state.

Employer Mandate

- Employers would be required to cover all employees and dependents working 17.5 hours or more per week. Self-employed and small employers would receive increased tax benefits to ease any financial burden.
- Medicaid would be expanded to cover all persons living below poverty regardless of categorical eligibility.
- State risk pools would be created to offer coverage to those not insured through another source. Persons with incomes between 100 and 150 percent of poverty would receive premium subsidies on a sliding scale.

Consumer Choice

- Employers would be required to cover all full-time workers (25 or more hours) and pay 80 percent of the premiums and must pay a tax equal to 8 percent of wages for uncovered workers. Small employers may opt to pay an 8 percent tax in lieu of offering insurance to full-time workers.
- The current exclusion from personal income taxes of employer-paid coverage would apply only to the costs of providing the mandated benefit package.
- Nonworkers and their dependents would be covered under a public program; premiums and cost sharing would be subsidized for persons below 150 percent of poverty.

Public/Private Partnership

- Make all Americans eligible for a standard benefit without a means test through a combination of mandated employer plans on a play-or-pay basis and an extension of Medicare to all those age 60 or more, making Medicare the first payer once again with all other plans supplementary to Medicare, covering under Medicare 80 percent of costs in excess of \$25,000 a year for individuals covered by the mandated plan and covering employees with fewer than 25 employees.
- Parts A and B of Medicare would be combined in a single compulsory program, and anyone not eligible under an employer mandate would be automatically eligible for the same standard benefit under the government plan regardless of past contributions or insured States requirements in present law. Employee contributions to employer plans would be limited to 20 percent of the cost, and participation would be required unless the employee bought equivalent protection from private insurance.
- The standard benefit for both the employer mandate and the government plan would include the present Medicare benefit, a stop/loss provision of \$2,000 a year per family and certain clinical preventive services. Medicare would include the beginning of a long-term care benefit and phased-in limited coverage of prescription drugs.
- Low-wage, small employers would be subsidized. A system of regional budgeting covering both public and private expenses would be established. Medicaid would become entirely supplementary to the standard benefit as would private insurance and self-insurance plans. The government plans would pay their own way and end cost-shifting.

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- The cost of the additional Medicare benefit would be covered on a pay-as-you-go basis by earmarked taxes appropriate to a social insurance system, relying heavily on employer and employee contributions. Social Security and Medicare would be put on a pay-as-you-go basis, and the reduction in OASDI rates would be matched by increases in rates for the new Medicare program. Non-earners would pay a 3 percent tax on unearned income up to \$125,000 a year minus any income subject to the Medicare payroll tax. The Part B premium would be cut in half.
 - Overall responsibility for policy and administration would be lodged in a quasi-government organization governed by representatives of those receiving services and those providing them.

Individual Tax Credit

- All persons under age 65 would be required to purchase coverage. Employer-based insurance is eliminated. Instead, employer contributions for health benefits are converted to income.
- All private carriers would be required to adopt principles of open enrollment (medical screening or pre-existing limitation exclusions are precluded) and to set premiums using adjusted community rating principles that would allow premium variations to be based only on the age, sex, and geographic location of enrollees.
- Medicaid is eliminated for persons under age 65 for acute care (but retained for long-term care services) and replaced with a refundable tax credit for the purchase of private insurance.

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- Individuals may deduct the cost of the standard benefits package in determining personal income taxes, but may not deduct the cost of any supplemental coverage.

Universal Medical Expense

- The Federal Government would establish a universal plan to cover catastrophic illness; coinsurance and deductibles would be income-related. The plan would be secondary to all other coverage, public and private; i.e., only expenses that are not otherwise reimbursable through any other plan would count toward the income-related deductible.
- Employer tax deductions would be available only for "qualified" plans. Individuals would be permitted to deduct 50 percent of annual health insurance premiums up to \$250, and the individual tax deduction for unreimbursed medical expenses would be increased so that an individual could deduct such expenses above 2 percent of adjusted gross income instead of above the current 7.5 percent.

Public Health Insurance Model for Acute Care

- A public program would be established that would be fully Federally financed, largely through a payroll tax, and would provide comprehensive coverage to all Americans.
- Medicare and Medicaid would be subsumed under the new program.
- A system of global budgeting would be established for all providers.

The Federal Government, operating through the management structure described above, would issue an initial RFP to the States within six months of enactment of the authority to demonstrate the various prototypes. States would be required to meet data requirements that would be established and otherwise assist in any federally funded evaluation. We recommend that \$500,000,000 be appropriated to cover developmental, administrative, and evaluation costs and \$3 billion to pay for the additional benefits or subsidies associated with broader coverage. Assuming enactment in 1992, the prototypes could be implemented as early as the beginning of 1993, and certainly by the end of 1994, and results available in time for the adoption of a national plan in the latter half of this decade.

Research questions to be answered:

Generally, each of the above prototype models fall in one of the following categories: (1) increased individual responsibility; (2) increased employer responsibility; and (3) increased government responsibility. For each of these approaches, there are significant research questions and concerns about the potential behavioral responses and impacts. Even though some of the effects can be estimated, some of the most important cannot. For example:

- If individuals had more responsibility for their health insurance, such as in an approach where individuals rather than employers made insurance purchase decisions, would more or less insurance be purchased and what impact would this have on total costs?
- How would the insurance market respond? Would there be different packages offered than today? Is it the use of tax-preferred dollars for insurance purchase or the current purchase arrangements that leads to today's problems?

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- Would an increase in individual responsibility for paying for health insurance reduce access to care?
 - What would be the impact on total employee compensation?
 - What would be the impact on individual net income?
 - If all employers were required to provide a basic insurance plan, would this lead to a significant loss of employment and/or wages? What would be the impact on total employee compensation/costs? What would be the effect on different income groups?
 - Would employers who currently offer insurance reduce their coverage to the basic plan?
 - Would individuals purchase this coverage from their employers if it were made available?
 - If the government increased its responsibility for the high-cost cases, what would be the impact on private insurance premiums?
 - Would more employers or individuals purchase insurance?
 - Would an increased government role lead to queueing?
 - What is the relationship between the amount of government coverage (catastrophic vs. full coverage) and total health care costs?
 - If employees and individuals were allowed to buy coverage from the Medicare program, what would be the effects on private health insurance
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premiums? How much would favorable selection and competition contribute to any change in premiums?

The complete proposals and estimates for national implementation are found in Appendix D.

Prototype Medicaid Reforms

Improving Access to Medicaid Services

- Medicaid physician payment rates would be increased in rural underserved areas in order to attract physicians in nearby urban areas to establish part-time offices in the rural areas.
- Medicaid physician payment rates to primary care physicians in urban areas would be increased in order to deflect inappropriate emergency room care to more appropriate services.

Improving Medicaid Enrollment

- Alternative outreach approaches will be implemented to reach persons eligible for Medicaid but not enrolled. Groups in need of services will be targeted.
- Outreach approaches will include media-based campaigns, use of local non-profit organizations, personal canvassing, and others.

Improving Medicaid Coverage of the Uninsured

- States will designate certain covered services as non-essential and invest those resources into providing coverage for currently uninsured, Medicaid-ineligible individuals.
- Mechanisms will be established to monitor care and safeguard against deleterious effects on health status.

The Federal Government, operating through the management and oversight structure mentioned above, would issue an initial RFP to the States for the initial six months of inactment. States would be required to meet data requirements that would be established to otherwise assist in any Federally funded evaluation. We recommend that \$9 million be appropriated each year to cover developmental, administrative, and evaluation costs and \$1 billion to pay for additional benefits or subsidies associated with broader coverage. Assuming enactment in 1992, the prototypes could be implemented as early as the beginning of 1993 and data available by the end of 1994. The proposals can be found in Appendix D.

Research questions to be answered:

- Will increased Medicaid payment rates induce urban physicians to set up part-time offices in adjacent rural areas?
- Will increased Medicaid payment rates increase physicians participation in Medicaid?
- Which outreach strategies are most cost-effective in increasing Medicaid enrollment?

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- Will States increase numbers of persons covered by Medicaid if they can estimate coverage of specified non-essential services?

Prototype Medicare Reforms

With the exception of Medicare capitated plans, most applied research has focused on alternative approaches to payment of specific providers and not on comprehensive program reform. It is becoming clear that increasing the program revenues or decreasing benefits in light of the impending demographic changes and health care cost inflation is an inadequate strategy for the long term. The looming Trust Fund crisis may require fundamental reform, yet information on the impacts of alternative fundamental reform approaches is not available.

One approach to reform that many of the Council members believe should be tested on a nation-wide basis involves offering beneficiaries a choice of programs. These programs should not be required to provide savings to Medicare, but can be budget neutral.

Combined Acute and Long-Term Care Coverage

- Beneficiaries would be given a choice between the current Medicare program and a new comprehensive benefit program which pays for all Medicare services plus prescription drugs, long-term care, vision, dental and other services. This new program would begin paying for care after the beneficiary had incurred annual expenses of about \$35,000 or reached a 3-year or lifetime threshold amount.

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- Under the new plan, beneficiaries or their employers could purchase private health insurance to cover the up-front amount and could begin paying toward this policy in advance of age 65. If purchased at age 50, the monthly premium is estimated to be \$80.
 - The government would subsidize the cost of the private insurance portion for low-income elderly.
 - Managed care techniques would be encouraged for both the private and government components.

Medicare Voucher Plan

- Medicare would become a prefunded program providing vouchers to beneficiaries for the purchase of enhanced insurance coverage in the private market.
- Current Medicare benefits would be enhanced to include catastrophic coverage.
- Income-related deductibles would be instituted.

The Federal Government, operating through the management structure described above, would issue an initial RFP to the States within six months of enactment of the authority to demonstrate the two approaches. Assuming enactment in 1992, the prototypes could be implemented as early as the beginning of 1995 and preliminary results available in time for adoption prior to the influx for baby-boomer retirement.

Research questions to be answered:

- What are the numbers and characteristics of the beneficiaries attracted to each approach?
- How would insurers respond to the private insurance approaches?
- What would be the out-of-pocket cost of each approach?
- What are the favorable/adverse selection impacts for each plan and the effects on costs?
- If acute and long-term care were combined into a comprehensive package, what would be the impact on cost? Would there be substitutions of less expensive/more appropriate services and settings?

The complete proposals and cost estimates can be found in Appendix D.

In order to provide a framework for evaluation of the comprehensive, Medicaid, and Medicare Prototypes, the Council reserved criteria for evaluating health care reform proposals developed by the Expert Panel. The Council recommends to the oversight commission that they use these criteria in evaluating the prototype models and that the Secretary and Congress consider these criteria in evaluating national health care reform plans.

The Council unanimously agreed to adopt the criteria developed by the Expert Panel and reprinted here.

Effect on Opportunities for Underserved People to Receive Needed and Appropriate Health Services. It is important to acknowledge the distinction

between barriers to health care and barriers to health insurance. Having insurance only removes some financial barriers. Insurance does not remove non-financial barriers such as transportation and sociocultural barriers, inadequate numbers of providers, and regulatory barriers (e.g., excessive paperwork, low reimbursement). Conversely, one can have access to health care services in a direct service setting, for example, and still be uninsured.

Factors to consider include:

- financial barriers (e.g., through insurance or services free at point of delivery; role of deductibles and copayment);
- geographic and manpower distribution barriers (such as providers within a normatively-defined distance available at time of need);
- sociocultural access (language, customs, educational level); and
- range of services available, e.g., economical preventive services.

Distributional Effects of Who Pays in the Near-Term and in the Future.

The financing mechanisms being considered to support reform (business, payroll tax, income tax, tax credits, dedicated value-added tax, out-of-pocket payments, etc.) each have different distributional effects with respect to populations affected and impacts on other public program financing (e.g., Social Security).

Factors for consideration include both short-term effects and effects over the long term as a consequence of changes in demographics, distribution of wealth, utilization, etc. Examples include:

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- relative burden on works for health care of the elderly,
 - progressivity of financing,
 - financial burden on the individual in poor health, and
 - relationship between individual pay-in to social insurance programs and expected benefits.

Effect on Short-Term and Long-Term Economic Growth for the Nation.

Real per capita GNP is predicted to grow at an annual rate of 1.08 percent between now and 2020. Health care expenditures are expected to grow at a faster rate; thus, the share of GNP associated with health care expenditures may increase to between 22.7 percent and 38.5 percent in 2020.

Consider the extent to which a reform proposal imposes a moderating influence on the rate of growth of health care (with respect to the resources the Nation is willing and able to spend on health care) and its subsequent interactive effect on the overall economy. (It does not, however, consider the extent to which the economy might be stimulated to grow at a rate faster than predicted.) The precise relationship between health care costs and growth in the economy is not known.

However, as health care consumes a growing proportion of the nation's resources, there are fewer resources for other needs. Factors to be considered include effects in the near- and long-term of a proposal's incentives on:

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- the continued research, development and diffusion of cost-reducing technology;¹²²
 - the development and diffusion of cost-inducing technology of low utility;
 - medical technologies and services of low utility;
 - administrative efficiency;
 - the labor market (e.g., employment opportunities, job mobility);
 - rate of savings or investments;
 - U.S. economic position relative to foreign competitiveness; and
 - entry by new businesses and performance by current businesses in the marketplace.

Effects of Reform Implementation. Implementation of health care reform must consider the following:

- level of disruption,
- indirect consequences of reform,

¹²² As used in this criterion, technology takes on the broadest meaning as defined by OTA to encompass any "techniques, drugs, equipment and procedures used by health care professionals in delivering medical care to individuals, and the system within which such care is delivered."

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- administrative complexity of reform plan compared to the existing system, and
 - availability of data to measure the effect of changes and permit new experimentation and innovation.

Relationship Between Reform and American Culture and Values.

Acknowledging and understanding the different tolerance for specific values and principles embedded in a health care reform plan can help the consensus-building process. In practice, these beliefs and values can overshadow any technical merit a plan might otherwise achieve. The list below includes features and concepts that are often discussed as why one health care reform approach or another would not be acceptable:

- degree of access achieved,
- effect on pluralistic system,
- scope of government control,
- effect on freedom of choice,
- effect on quality,
- degree of burden placed on system participants, (e.g., insurers, providers, working aged consumers, poor),
- effect on provider autonomy, and
- regulatory or market-oriented incentives.

The Council believes that the policy dialogue over both system reforms and the processes for implementing those reforms will be enhanced if each participant defines its own priorities, values, and preferences independent of any specific proposal. In addition to serving as a consistent and reliable filter through which a group may pass and evaluate reform ideas, the resulting body of criteria can illuminate points of consensus and identify opportunities for negotiation, further development, or compromise.

Revenue Options

In light of today's necessary climate of fiscal restraint and the strictures imposed by the Budget Enforcement Act, the Council feels strongly that it would be irresponsible to propose any new Federal spending without suggesting sources of revenue which could be used to offset those expenditures. Accordingly, the Council outlines below revenue sources to fund the Council's recommendations.

The Council wishes to stress, however, its preference for adopting "offsets" which are health-related in nature, that is, which encourage changes in personal behavior or in the health care marketplace and lead to improved health outcomes in the United States. Prime examples are increasing cigarette and alcohol excise taxes.

Further, the Council recommends that budget policy makers adopt revenue sources which can serve to refocus the direction of current Federal spending to emphasize new initiatives which improve the health of our Nation's populace, especially children.

Following are \$27.5 billion in revenue-raising options for 1992-1994 which the Council suggests be considered as sources of funding for its health care initiatives outlined in this chapter.

Increase Excise Tax on Alcoholic Beverages. The current excise tax on distilled spirits is \$13.50 per proof gallon, on beer is \$18.00 per barrel, and on wine is between \$1.07 and \$3.30 per wine gallon. The Congressional Budget Office has estimated that increasing the tax to \$16.00 per proof gallon, equivalent to 25 cents per ounce of alcohol, would raise over \$3.3 billion in one year. Doubling the increase in out years would yield \$16.8 billion over three years.

Revenue Generated: 1992: \$3.3 billion, 1992-1994: \$16.8 billion

Increase Cigarette Excise Taxes. Excise taxes on cigarettes are currently 20 cents per pack, having risen from 16 cents per pack last year. Although the tax is slated to increase to 24 cents per pack in 1992, further increases could be warranted given the current low rate (in terms of constant dollars) and the costs to society of tobacco-related illness and death. As the Congressional Budget Office has noted, the 8-cent-per-pack tax in 1951 would be 35 cents today if the figures were adjusted in terms of constant dollars. Increase the tax to 32 cents per pack the first year and double the increase in out years.

Revenue Generated: 1992: \$1.2 billion, 1992-1994: \$5.7 billion

Index Current Cigarette and Alcohol Taxes for Inflation.

Notwithstanding provisions in the Omnibus Budget Reconciliation Act of 1990 which raised substantially excise taxes on cigarettes, beer, wine and other alcoholic beverages, if adjusted for inflation, Federal tax rates on

alcoholic beverages and cigarettes still remain substantially lower than they have been at any time since 1951. Indexing these taxes for inflation would not only raise revenue but could also discourage the social costs of consumption such as lung disease, cancer, alcoholism, or drunk-driving fatalities.

Revenue Generated: 1993: \$0.3 billion, 1993-1995: \$5.0 billion

Conclusion

Throughout its public hearings, the Council heard from witness after witness who poured out his or her vision of health care reform, of health care security. The Council has great confidence that, utilizing this Report as a framework, the American people can begin to make great progress in realizing their hopes for cost reduction and meaningful structural reforms in communities throughout this land.

The next few years offer a window of opportunity for policy makers to consider how best to meet that challenge. None of the options is easy. None can reduce cost without running the risk of reducing beneficiary well-being. All require a balance of fairness in the share of the burden that is to be borne by working-age persons and by the elderly themselves. The Council recommends that major policy decisions about the design and financing of health care should be developed, not solely in annual budget negotiations, but rather from a long-term perspective that aims to design the best possible health benefit program for all Americans, given the resources that the Nation is willing to devote to the purpose.

ADDITIONAL VIEWS

Arthur L. Singleton

This Advisory Council on Social Security has produced findings and recommendations which should expedite the development and enactment of a fair and effective health care system for all Americans. There is no consensus apparent today among the people or their political leaders on how to achieve that goal, but movement toward it should be accelerated rapidly by the substantive material in the Council's final report.

Some Council members have expressed regret that agreement could not be reached on a single universal health care plan. I believe that such a conclusion would have been a great mistake at this time. No such scheme produced to date has met the tests of public acceptability and economic viability; more empirical information is needed for success, and this report should help in that regard.

With respect to the Council's recommendations for immediate action, I believe they represent good ideas which, if implemented appropriately, will address some of the most critical and acute problems in current health care law and practice. As a believer in individual rights and freedom of choice, however, I want to express my general disagreement with parts of such proposals which call for governmental banning of products or services.

With respect to the Council's recommendations on the Old Age, Survivors and Disability Insurance (OASDI) programs, I want to register a lament that some serious DI problems were not addressed. One example is the extent to

which the appeals process has become so complicated that many claimants believe they must hire attorneys or other professional helpers in order to be justly treated. This sort of procedure was not desired by the framers of the DI program, and I do not think current policy makers really want it, either.

Karen Ignagni and John Sweeney

When the Advisory Council issued its interim recommendations on Social Security, we stated our concerns about the prudence of continuing partial reserve financing and proposed, instead, a policy of moving to a pay-as-you-go system once an adequate contingency reserve was established in the Trust Fund. We iterate this position and offer comments on three other issues.

Social Security Staffing Crisis

We urge Congress to remove from overall budget calculations the administrative funds necessary for the Social Security Administration (SSA) adequately to carry out its responsibilities to working Americans and current—as well as future—beneficiaries.

The funds to administer the programs should come from the Social Security Trust Funds and should not be tied to the unified budget. We interpreted last year's legislation removing the Trust Funds' income and expenditures from deficit reduction calculations also to have included SSA's administrative accounts. Since this is a matter of some dispute, we urge Congress to clarify the intent of the legislation and to assure all Americans that the program is being run properly.

At this juncture, concern is warranted. Since 1984, SSA staff has been cut by almost 25 percent. This has translated into a 45 percent reduction in clerical staff, a 49 percent reduction in field staff, a 33 percent cut in service representatives, and a reduction of 89 percent for data review technicians.

We believe that the SSA no longer has enough personnel to carry out its mission and that these dramatic cutbacks have compromised the flow of information about program procedures to beneficiaries. In addition, these reductions have contributed to concerns about whether the agency has the staff necessary to record workers' earnings accurately and to ensure that there are no gaps or incomplete, duplicate, or erroneous postings.

Two frequently cited examples provide evidence of what the staffing shortage has meant for the agency. The SSA operates a national toll-free telephone number, but its average busy signal rate is now 63 percent. Disability cases are at an all-time high. The pending case load is estimated to be 800,000 nationwide. This translates into waits of several months to more than a year.

Clearly, such inadequacies should not continue. We hope that the Congress will act expeditiously to clarify the underlying budget issue and give the SSA the resources it needs to carry out its essential mission.

Coverage of State and Local Government Employees

We oppose the Council's recommendation mandating OASDI coverage for all newly-hired employees of States and localities, because further expansions in OASDI coverage at this time are unwarranted and inappropriate.

In July 1991, mandatory OASDI coverage was extended to 3.8 million public employees not covered by their employer's pension plan. According to the Congressional Budget Office, this change alone will cost States and localities \$2 billion annually. Greatly intensifying the impact of this very recent change is the fact that this burden is not spread evenly across the country but, rather, is concentrated in a handful of States and localities.

In view of the continuing recession and the condition of most public budgets, further expansions of OASDI coverage cannot be recommended. Such a change would amount to nothing more than another instance of the Federal Government shifting fiscal burdens onto other levels of government—a very poorly timed action. Further, in addition to the direct cost, this change would lead to creation of administratively unwieldy and inequitable two-tiered pension systems covering new hires.

Investment of Social Security Assets

On the issue of investment of Social Security assets, we recommend that Congress request the General Accounting Office to study the pros and cons of continuing the current policy of investing in Treasury bonds and to identify and evaluate alternative investment vehicles that could be pursued if this policy were to be changed.

We note that the conclusions of the 1959 Advisory Council often are cited as the overriding operating statement on investment of assets in the Social Security trust funds. That Council ratified the practice of investing only in government obligations, raising concern about how other investment strategies would affect the private sector or the affairs of State and local government. Over the more than 30 years since that report was issued, the sheer accumulation of capital in employment-based pension plans has

required new thinking and, ultimately, the development of new policies for pension fund investment.

We believe that now is the time for an in-depth examination of Social Security investment practices. Key issues concerning the impact of change in investment policy on the Nation's fiscal policies, as well as the security of plan assets, should be addressed as part of such an examination. We also would urge that a study of whether Social Security ought to invest in private sector stocks and bonds include a discussion of what overriding investment policies and guidelines would be needed to ensure beneficiaries that assets would be invested and managed effectively.

In analyzing alternatives for State and local investment, we would encourage a discussion of the pros and cons of State and local bonds, as well as other vehicles that exist in the private sector, to encourage investment in infrastructure. We also would urge that the study contain a discussion of how the responsibilities of the trustees would have to change if new investment policies were pursued and whether the current trustee structure would be adequate to guarantee productive and effective administration.

G. Lawrence Atkins

Along with our other responsibilities, this Advisory Council has been charged with responding to the anticipated insolvency of Medicare's Hospital Insurance (HI) Trust Fund shortly after the end of the decade. Years of isolated Medicare reforms have done little more than briefly postpone its insolvency. As a result, this Council has chosen to place the resolution of Medicare's problems in the context of a broader restructuring of the financing of health care in America.

It is ironic that a nation with the world's most advanced methods for delivering health care should have one of its most poorly developed systems for paying for it. The haphazard approach we have evolved for financing health care has left one-in-six non-elderly Americans without health insurance, has distributed the costs of care inequitably, and has contributed to a growing financial crisis for both providers of care and payers.

As this Advisory Council has rightly noted, our fundamental national concern in this area is to ensure a healthy population with adequate access to needed health care. Health insurance is only a vehicle for ensuring access to care, and care is often only a response to changes in health status. Yet a failure in that financing vehicle can reduce the availability and quality of health and can affect the underlying health status of the population.

This Nation cannot maintain the financing system we now have beyond the end of this decade, given our current rate of growth in health care costs. For one, the acceleration in health care spending is outpacing most other activities in our economy. With or without growth in other sectors, we are realigning our priorities by diverting an additional percent of Gross Domestic Product from some other use to health care every 30 months. Even if this trade-off of other consumption for health care were acceptable in a societal context, the burden on productivity resulting from rising labor costs and higher taxes threatens to reduce the competitiveness of our businesses and the economic well-being of our citizens.

The future costs for Medicare in particular, and health care in general, are alarming. The Advisory Council's Expert Panel on the Future of Income Security and Health Care Financing, in its vision of the year 2020, suggests that the income gains of workers over the next 30 years may be offset by the rising costs of health and income support programs for the elderly. It

suggests that Medicare will consume about 6 to 8 percent of GNP in 2020 compared to 2 percent today, and that the payroll tax for just the HI fund (Medicare Part A) may rise to a combined rate of between 6.4 and 8.9 percent compared to 2.65 percent today. At the same time, the Expert Panel anticipated that older persons' out-of-pocket payments for health care will rise dramatically from less than 9.5 percent of average retirement income today to over 22 percent in 2020 (without accounting for nursing home care).

Beyond Medicare, the Expert Panel estimates that under moderate assumptions about future costs (including a 5 percent reduction in the historical rate of growth), total health expenditures will account for as much as 31.5 percent of GNP by 2020.

What is remarkable about this growth in spending is that it is expected to occur before the baby-boom generation begins to retire. Less than 10 percent of the anticipated spending increase is attributable to demographic changes. In fact, the Expert Panel concludes that changes in the intensity of health services ". . . are the major factor underlying the real growth in health spending." The Panel goes on to say that ". . . it is clear that attempts to limit the projected increases in health spending will need to address the factors that underlie the growth in health spending, particularly the rate of technological change." To achieve a substantially slower rate of growth and thus a lower proportion of GNP allocated to health care than the 22.7 to 31.5 percent in 2020 foreseen by the Expert Panel would require ". . . immediate and drastic policy intervention."

Despite the view of many on the Advisory Council that there is an urgent need for immediate comprehensive reform of our health care system, this Council has, regrettably, been unable to reach agreement on any one

comprehensive reform approach. The Council has, nonetheless, agreed on a number of conclusions which I feel are significant.

In my view, we have concluded that there is urgent need for a nationwide restructuring of our health care financing system to provide health insurance coverage and slow the rate of growth in health care costs. It is important, in my opinion, that we seek a single national approach that will benefit equally employers and employees in small States and large States and those that operate in a number of States. While the Federal Government may encourage States to experiment with various designs while the Congress prepares to enact legislation, there is no benefit in the long run to maintaining 50 separate health care financing systems all working at cross purposes.

The Advisory Council has also approved a number of sound ideas for providing direct health services, improving the availability and affordability of health insurance, and lessening the rate of increase in spending. All of these can improve the financing and delivery of health care in the short run and may contribute significantly to the long-term goal of comprehensive reform.

In my judgement, the sum of the Advisory Council's recommendations are a call for immediate action by the Congress, not a justification for delay. While we have not agreed on an exact approach to comprehensive reform, we have shown through the variety of reform proposals presented in this report a clear belief that there should be comprehensive reform. We have committed to a program to enable the States to work through many of the implementation details of reform while legislative drafting proceeds at the national level. We have also proposed a number of national institution-building measures that can prepare the foundations for reform. These include

a single national electronic claims processing system, a national commission to monitor State innovations and report on national trends in health care utilization, and an enhanced and coordinated technology assessment capability.

All of these recommendations provide additional momentum toward a nationwide restructuring of our health care financing system. We have not agreed to a means for averting the insolvency of Medicare's HI Trust, but we have made a significant contribution to the debate that, I believe, will bring this Nation closer to a consensus on broad reform.

Robert Ball, John Dunlop, Karen Ignagni, and John Sweeney

We regret that we must disassociate ourselves from the main conclusion of the health care proposals incorporated in the final report of the Advisory Council on Social Security. The Council's majority position would unfortunately postpone—until at least the end of the decade—the day when all Americans can be assured access to adequate health care at a reasonable cost.

When the Council was appointed in 1989, it was given a broad mandate not only to assess the adequacy of our existing social insurance system—of which Social Security and Medicare are the principal pillars—but also to examine the crucial issues facing our health care system as a whole. The Council carried out part of its assignment, vigorously collecting data and contracting for many background reports. Much of this work has been useful. But that should not be allowed to obscure the fact that the Council has ducked the toughest issue.

The single most important challenge facing the Council was to devise a coherent, comprehensive response to the urgent need to provide adequate health care for all Americans at a cost that our society as a whole can afford. Indeed, this was both a challenge and an opportunity. Previous Social Security Advisory Councils have been able to transcend political differences for the common good—notably in 1983, when a bipartisan Council saved Social Security from a funding crisis. But this Council has avoided the challenge of reconciling differences and has missed an opportunity to get the Nation moving rapidly toward a resolution of the present health care crisis.

Instead, the Council offers a variety of recommendations that could become elements of a comprehensive strategy but are not themselves a substitute for such a strategy. To offer them without a context—that is, without reference to how each of them could fit into the overall framework of a universal health protection program—makes the Council's report useful only as a shopping list. In essence, the Council urges us to buy some new furniture for a house that is on the verge of collapse. The more urgent task, we suggest, is to rebuild the house.

The Council proposes, for instance, to offer health insurance on a voluntary basis to many school-age children of parents who either lack coverage entirely or who have inadequate coverage. The political appeal of this proposal is obvious. The Council will be able to say—as will President Bush, if he embraces this approach in his State of the Union message—that "we have made a commitment to protect America's children." Campaign rhetoric aside, however, the inescapable fact is that limited initiatives of this kind simply will not provide adequate protection for children or the population as a whole and will not control the runaway costs that are at the core of America's health care crisis—costs which if not curtailed will be consuming 17 percent of GNP by the end of the decade.

Our health care system is increasingly beyond the means of middle-class Americans, even those with insurance. Not so long ago, it was almost an article of faith that if you had a decent job you could count on getting decent health benefits. No longer. Not so long ago, you could make career decisions on the merits of a job; now your first consideration is likely to be whether your health insurance will be affected. Not so long ago, wages were basic and benefits were called "fringes." Now it's the other way around: workers regularly forego wage increases (and diminish their buying power as consumers) in order to hold on to their health insurance. And a large part of the fear of unemployment is the fear of losing health insurance coverage.

All this has happened because America's health care system has developed a dangerously split personality. The system provides first-class care—arguably the best in the world—to many people, and grossly inadequate or even nonexistent care to many others. Access to adequate care has increasingly become less a right than a privilege. You have to be able to buy your way in—and for millions of Americans, the price of admission is impossibly steep and getting steeper.

The cost of health care will not be brought under control until three things happen. First, as a society we must be willing to say that access to health care should be at least as basic a right as access to education. Second, health protection must be extended to everyone, so that the insured and their employers are no longer carrying the burden of paying for the uninsured. Only when all are contributing—at least as equitably as individual circumstances allow—can the costs of insurance be fairly distributed. Third, the overall cost of providing health protection must be brought under control by imposing economic discipline—controlling the costs associated with the delivery of health care. That can only be done by adopting nationwide a reasonably uniform and consistent approach to the purchase of health care

services. In the absence of such a system, we have insufficient leverage with which to control health care delivery costs; we are at the mercy of a market that cannot possibly control itself.

Indeed, health care professionals are themselves at the mercy of this system. They, like the rest of us, are trapped in a haphazard, unplanned, uncoordinated system in which no global budgeting ever takes place. There are perverse incentives in the system to maximize duplication of expensive technologies and no ways to control unnecessary procedures. In addition to its other evils, this fragmented system provides few incentives for preventive care, and health care delivery innovations are themselves at risk of being overwhelmed by the rising cost of nearly all health-related services—everything from administrative paperwork to malpractice insurance.

That these costs are now out of control is obvious to all involved in the delivery of health care—providers, consumers, and third-party payers alike. Rather than confront this problem head-on, however, the Council, after more than 2 years of deliberations on the entire range of health care problems, has opted to avoid dealing with the overriding policy issue by retreating behind the oldest of rationalizations for delay, a call for further investigation.

The Council majority justifies this by maintaining that there is "no clear consensus" on how best to provide universal access to health care and that "the divisions within our Council over the best long-range policy course reflect divisions within the United States as a whole." Divisions there may be, but in fact the debate has long since reached the point where a solid majority of Americans say they want leadership to solve the health care crisis—and will vote for it, as recently demonstrated in Pennsylvania.

We believe that a basic consensus for universal health security exists. The challenge is not to create a consensus but to build on it—and work out the details.

The Council, however, says we need more experience before we can act. This claim—coupled with the doubtful notion that demonstration projects are needed to help rally public opinion behind more fundamental reforms—becomes the rationale for calling for an assortment of experiments that might or might not be of value but that would assuredly postpone the day when the United States catches up to the rest of the industrialized world and provides universal health care protection. Indeed, the Council proposes having such a plan in place "by the beginning of the next century." We say there is no justification for that kind of delay.

When the flood came, Noah did not build demonstration arks. It seems ludicrous for the United States—still the wealthiest and arguably the most resourceful Nation in the world—to take the position that further study is needed at a time when all other industrialized nations, with the exception of South Africa, have for many years provided universal health coverage programs and have moved ahead, refining and improving their programs on the basis of concrete operating experience, rather than endlessly debating whether to start.

Events have overtaken the Council. The uninsured, the underinsured, the millions of Americans who fear losing their insurance on the job or who dare not change jobs for fear of losing coverage know that we cannot afford to delay implementing universal health protection until the end of the decade. Businesses that offer health care coverage to their employees are finding it increasingly difficult to compete internationally and at home. They know the importance of requiring all employers to do their fair share. Policy makers

who must sooner or later find a way to bring the sharply accelerating curve of health-care costs into alignment with other societal costs know that the Nation will pay an intolerably high price for delay. For that matter, the Council's own technical committee, in its executive summary, warns that the United States must move as rapidly as possible to a program of universal access coupled with cost controls.

The problems of arriving at agreement on a national health care plan are no longer primarily ideological. They are problems of different interests among major participants. To resolve them, we do not need demonstration projects. What we need is a bipartisan demonstration of good faith.

It would be the essence of national leadership to bring together representatives of the principals—health-care providers, purchasers, and consumers—and to instruct them to negotiate nonstop until they have agreed on the outlines of a national health plan. Negotiating such an agreement would not take them years. In fact, the Advisory Council could have been that vehicle.

We do not have to start from scratch. This is a key point, and one that is at odds with the Council's notion that we need more experience. We can build on the vast experience that the United States has already acquired—not only in creating but also in nurturing (and modifying when necessary) social insurance programs that have been both hugely popular and hugely successful in contributing to the well-being of our society as a whole.

By alleviating poverty among the elderly, for example, Social Security maintains the self-sufficiency and purchasing power of millions of people. By making access to health care universally available to the elderly and the

long-term disabled, Medicare creates a stable framework both for providers and for consumers of health-care services.

Just as Social Security rationalized the otherwise brutally unfair and inequitable costs associated with the inevitable loss of one's earning power, and as Medicare rationalized the otherwise overwhelming costs of providing health care to the elderly, so can universal health protection rationalize the delivery of health care as a whole, at a cost that our society can afford. Rather than argue over whether such a system can work flawlessly in a society as complex as ours, the Nation needs to acknowledge what is now so clear: the alternative is worse. More importantly, and more positively, we need to recognize that we have the expertise to do the job—thanks to decades of experience not only with Social Security and Medicare, but also with employment-based health care.

How do we get there from here? Historically, the best characteristics of insurance programs, both public and private, have evolved through what amounts to an ongoing, open-ended process of negotiations. These have been complex affairs, often overshadowed by higher-profile political posturing, but in the many instances where they have been successful, the main reason has been that representatives of different interests have found ways—often under intense pressure—to accommodate each other for the common good. This is, after all, the essence of successful negotiating in any field. If we are to move away from the present state of disarray in health care, we must feel pressured to negotiate and we must be prepared to negotiate in good faith.

We take as a starting point the following principles:

Access to health care should be a universal right. All Americans should be eligible for a standard package of health security benefits regardless of income or assets.

Paying for health care should be a universal obligation. All working Americans and their employers—and all other Americans who can—should contribute to paying the costs of a universal health security program through equitable and progressive financing.

Controlling the cost of health care should be a universal concern. The administration of a nationwide health security plan should be under the active guidance of a national commission in which the interests of all those involved in providing and purchasing health care are represented. Through a process of continuing negotiations, the commission should be responsible for developing global health care budgets, uniform payment rates, quality of care standards, guidelines for rational deployment of technological and other resources, and priorities for distribution of preventive care services and other cost-containment measures.

The Council in its final report supports a set of principles essentially similar to these. But having gone that far, the Council fails to take the logical next step. Rather than acknowledge that there is already broad popular support for these principles, the Council argues against acting on a comprehensive nationwide scale until popular support trickles up, in effect—a process that the Council sees as being stimulated by the proposed demonstration projects. We reiterate, however, that broad support for a nationwide initiative already exists and that further delay is unwarranted and costly. The overwhelming need now is for national leadership.

In advocating negotiations toward enactment of a health security plan based on these three fundamental principles, we cannot predict the results of the negotiations. Nor do we pretend that there are simple issues to be addressed.

The basic point, however, is that we can resolve these issues only after making an unequivocal commitment to resolve them. Under the present fragmented system, our problem-solving opportunities are limited. No matter how worthwhile they may be, no collection of piecemeal approaches—from in-school clinics to living wills—will do much to control the overall costs of health care in the United States or to redress the inequities of access and quality of care. Only a coordinated approach can offer that kind of hope.

We can have universal health security—and soon—if we commit ourselves to getting on with the job. To advocate anything less is to accept the inevitability of continued chaos in which the Nation's resources continue to be misapplied and sucked into a black hole of uncontrollable costs. No amount of rhetoric about the virtues of demonstration programs can hide that fact.

The Advisory Council on Social Security was given a rare opportunity to serve the interests of all Americans by setting in motion a process to protect us all against the economic consequences of illness while reconciling our differences about how best to pay for that protection. It is in sorrow rather than in anger that we say the Council has failed in its major mission. Because we believe the time for bold action is now, and because the majority of the Council has adopted an approach that we believe is entirely inadequate, we must and do object.

John K. Meagher

While I endorse fully the recommendations of the Council and believe that the cumulative work it, the staff, and the outside experts have done will greatly enhance the public debate on the health policy issues facing our society, I also believe some additional comments on the economics of health care are necessary.

As our Expert Panel report, *Income Security and Health Care: Economic Implications, 1991-2020*, pointed out in exhaustive detail, if America continues on its present path of consuming health care, by the year 2020, 31.5 percent of our GNP could be devoted to health care expenditures. And, importantly, that projection assumes that our economy grows by about 4 percent per year in each of the next 29 years. Given recent experience, the latter is totally unrealistic and our ability to absorb the former is unprecedented. Simply, these projections are staggering. If fulfilled, it would amount to the liquidation of America.

The only reasonable conclusion of such a projection is that any notion of expanding health care services in a significant way now is not possible. To the contrary, if this society is to survive, we must find ways to reduce, in real terms, our health care expenditures. It was for this reason, mainly, that the Council majority did not and, in fact, could not responsibly advocate the immediate implementation of a new broad-based, universal health care plan for America. Neither did the minority. Their failure to recommend a single plan apparently means that they were unable to agree on its substance. What this all says, I believe, is that imposing a new universal type plan on top of our existing system from an economic standpoint would be akin to pouring gasoline on a fire.

In fact, the real dividing line in the Council and, probably, in the political debate which will follow our report, is over whether cost containment must precede universal coverage or follow it. The Council majority believes the former, the minority the latter. While I know those who advocate "any plan now" have the best of motives, there is little or no evidence to support their view. In fact, our experience with Medicare and Medicaid is the opposite.

This is not to say, however, that universal coverage is considered an illusion or an unattainable goal. I believe every Council member supports not only this objective but also specific plans which would provide for it. I advocate the individual mandate plan funded by tax credits because I am convinced that it, more than any other of the ideas put forth, contains an inherent and continuing cost containment feature—individual responsibility for health care decisions. This proposal has many advantages over the traditional employer-based universal coverage plans. It would insure that all Americans have basic coverage but it recognizes that different families have different health care needs. It also takes into account geographic difference in costs of health care services as well as differences in income levels. It has much to recommend it and I hope both the Administration and the Congress will consider it seriously.

Yet, I do not believe it wise to move forward on this or any other plan now, absent a debate on setting a priority on national health care. In my view, that must come first, and it must not only begin immediately but also involve all political, social, and economic elements in our society. In this connection, the Council is recommending \$3 billion for testing many of the various plans which have been promoted as ideas for a national system. The results of these demonstrations should greatly enhance the information available to policy makers on what works and what does not.

Critical to this debate, however, is the President of the United States. He must, and, I believe, will lead it. He must tell the American people the facts about the economics of health care, and others in the debate, too, must play it straight rather than panning platitudes to the electorate as some have done recently. This is deadly serious stuff, and the worst result for all of us, rich or poor, with or without insurance or access to care, would be to deceive the American people by telling only half the story or to make a mistake by enacting a plan without a full debate and additional information. The American people must be told in specific terms of the costs involved in any plan as well as those which will exist if no new plan is enacted. They must be informed of the trade-offs, of the winners and the losers, and of the consequences any plan will have on other priorities of our society. As Council members, I believe we will have a continuing responsibility to do whatever we can to keep the debate honest, informed, and realistic. If we do that and if the debate is real, I have every confidence that the American people will make the correct, although difficult, choices not only for themselves but also for the generations to follow.

This is the reason I submitted these views and this is the reason I intend to continue to speak out for a responsible debate.

Philip Briggs

I would like to commend the Advisory Council on Social Security, and particularly its Chairperson, Deborah Steelman, on its work in identifying the urgent needs of our Nation's health care system and for addressing these needs through recommendations that improve access to health care for Americans, reduce significantly the rate of growth in health care costs,

reform fundamentally many of the basic health care institutions, and involve fully the American public in a commitment to change.

The Advisory Council on Social Security has done a conscientious job in deliberating the problems that surround the health system reform issue. The Advisory Council has thoroughly examined the present state of our health care system through testimony presented at field hearings and site visits, presentations of health policy experts on a variety of proposed solutions, and extensive discussions among members. As the Advisory Council continued its endeavors over the past two years, it became increasingly apparent that it would be impossible to bring such a diverse group to a consensus around a comprehensive health reform proposal to overhaul the Nation's health care system. However, the Advisory Council has recommended a set of substantial incremental reforms that lay the groundwork to correct the weaknesses in both the health care delivery system and its financing system. These reforms must be accomplished immediately to address the current problems of access to, and high cost of, health care as well as improving the quality of health care.

Recommendations to improve access to health care for the uninsured include enabling small businesses to obtain health care coverage for their employees through reform of the small group insurance market and investing approximately \$3 billion in (1) school area clinics, (2) establishing 250 new community health centers, and (3) doubling the size of the National Health Service Corps budget. The high cost of health care is addressed through recommendations that establish an Advisory Council on Health Claims Standardization and promote the use of managed care through a Federal preemption of State antimanaged care laws. Quality-of-care concerns are addressed by providing increased funding for outcomes research and the development of medical practice guidelines.

All of these incremental changes to the health system will go a long way toward increasing access to health care for millions of Americans, especially children. These changes will also begin to control the rate of growth of health care expenditures as well as improve the quality of health care for all Americans. For these reasons, I strongly support the Advisory Council's recommendations, which represent a commitment for immediate change in our health care system.

Health One

December 18, 1991

Deborah Steelman
Chairman
Advisory Council on Social Security
Washington, D.C.

Dear Debbie:

Unfortunately, I will not be able to attend the December 19 press conference in which we release the final report of the Advisory Council on Social Security.

However, I do want to express my complete support for the report and strong endorsement of its recommendations.

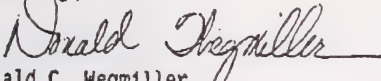
I believe the specific immediate action measures proposed by the council will do a great deal to improve access to health care, particularly for the targeted populations such as school-age children.

The "double-barreled" approach the Advisory Council took is, in my opinion, very creative and very reality based. The "first barrel", a series of specific program recommendations that could and should be implemented immediately, would do a great deal to improving health care access for a broad segment of the currently uninsured. The "second barrel" of the concept, a series of demonstration projects for broad-based health system reform, recognizes that we need a great deal of real knowledge, not theoretical planning, before we change the entire shape of the American health delivery system. To that end, the demonstration projects proposed are creative, represent some of the best current thinking on reform measures, and will yield the kind of reality-based experience the country needs before a complete reform of the American health system.

This "double-barreled" approach has my complete support and I believe will go a long way toward dealing with the two major concerns in our health system; access to health care and the cost of health care.

I was pleased to be a part of this advisory council and believe we have put forth some exciting reality-based recommendations.

Sincerely,



Donald C. Wegmiller
President and Chief Executive Officer
HEALTH ONE CORPORATION

Appendix A: Historical Background

Income Maintenance, Health Care
Delivery and Related Developments

HISTORICAL BACKGROUND

1800 AND EARLIER

Income Maintenance

Social Insurance

(Social Security and other non-needs-test public benefits.)

Public Assistance

Public aid to poor under colonial and early State laws modeled on Elizabethan Poor Law; e.g., in Virginia, care of needy aged, ill, widows, and orphans administered by Anglican vestrymen. Charity financed by tithe.

1730s - Most East coast towns had almshouses as one means of caring for poor.

Private Sector

1759 - Pension Plan for widows and children of Presbyterian Ministers—first such plan.

1794 - Galattin Glassworks' profit-sharing plan.

Health Care Delivery

Social Insurance

(Medicare and other non-needs-test public benefits)

Private Sector

1790 - The Boston Marine Society appointed a committee to establish a marine hospital supported by a Mariners' pay tax.

Other Related Developments

1636 - Plymouth Colony settlers' military retirement program.

1789 - Federal service-connected disability benefits for veterans.

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- 1790 - Pensions for disabled Revolutionary War officers (and survivors).
 - 1798 - Marine Hospital Service (forerunner of the U.S. Public Health Service) established by the Federal Government for care of American seamen.
 - 1799 - Congress established Naval Home (Philadelphia) which opened in 1832.

1801-1850

Income Maintenance

Public Assistance

- 1827 - New York law required residence in local area for eligibility for local aid.
- 1836 - Pennsylvania law required prior residency and property ownership for subsequential aid.
- 1836 - Many States (including Pennsylvania) required relatives to support needy kin.

Private Sector

- Early - Development and growth of private charity (as opposed to 1800s "almshouses" or "poor farms"); e.g., 1918 (Quaker) New York Society for Prevention of Pauperism founded. By 1837, there were 30 to 40 almsgiving organizations in New York City.
- 1831 - First trade-union unemployment insurance plan adopted.
- 1843 - New York Association for Improving the Conditions of the Poor (AICP) formed to study and provide standards for charities.
- 1850s - States begin to regulate insurance.

Health Care Delivery

Social Insurance/Public Assistance

Almshouses also housed sick or injured persons—"poor man's hospital." (Bellevue Hospital in New York, General Hospital in Philadelphia, and others began as almshouses).

Private Sector

- 1847 - AMA founded.

Other Related Developments

- 1802 - Early health care of Indians: Army Doctors gave smallpox vaccinations.
- 1811 - First Federal service benefit for veterans—domiciliary care for needy disabled veterans. Homes provided incidental medical care and rehabilitation services.
- 1818 - First non-service-connected Veterans' pensions. (Non-service-connected widows pensions provided in 1836.)
- 1824 - Bureau of Indian Affairs created in War Dept. (Transferred to Department of the Interior in 1849.)

1851-1900

Income Maintenance

Social Insurance

- 1855 - Georgia passed State law modifying common law approach to compensation for work injuries, making railroads responsible for injuries due to negligence.
- 1857 - First municipal pension fund established, providing disability and death benefits for New York City police. (Retirement benefits were added in 1878.)
- 1885 - Alabama passed first State Employer Liability Law, similar to 1880 English Employer Liability Act.
- 1894 - First statewide legislation for teachers' pensions enacted (New Jersey).

Public Assistance

General trend toward increased "out door" relief (as opposed to reliance on almshouses). Also significant corruption uncovered in some public programs, e.g., relief suspended in New York City 1874-75; in Brooklyn 1878. In some areas, public relief funds were channeled through private charities. (1869-79 California State-subsidized private relief organizations.)

- 1898 - First State law providing pensions for the blind enacted (Ohio).

Private Sector

- 1875 - American Express Company (later Railroad Express) established pension plan providing benefits for employees 60 or older, with 20 years with the company, who were incapacitated for further performance of duty. Entirely employer financed.
- 1877 - First American Charity Organization Society (COS) funded in Buffalo; by 1892, there were over 90 COSs. The COS movement involved organizing private charity, use of friendly

visitors, so that "out door" relief could be minimized. (COSs largely replaced AICPs [see 1843].)

- 1880 - First U.S. railroad plan supported by employer and employee contribution (Baltimore and Ohio Railroad Company).

Health Care Delivery

Social Insurance

- 1870 - An Act to reorganize the U.S. Marine Hospital Service and to provide for the relief of sick and disabled seamen.

Public Assistance

- 1855 - California law making counties responsible for care of indigent sick, either in almshouses or through out door relief.

Private Sector

- 1872 - American Public Health Association founded.

Other Related Developments

- 1851 - New Hampshire formed first State insurance regulatory body. Three more States did so by 1860. In 1868, the Supreme Court found (in *Paul v. Virginia*) that insurance is not "commerce" and thus may be regulated by the States.
- 1851 - U.S. Soldiers' Home, Washington, DC, established.
- 1854 - President Pierce vetoed bill to provide land grants to states to help finance mental hospitals. Many State Institutions for mentally ill founded in late 1800s.
- 1855- - Military pensions were established and expanded as follows:
- 1890 1855, pensions provided for Naval officers no longer able to perform; 1861, provision for retirement of Regular Army officers; 1862, General Law provided pensions for all Civil War veterans with service-connected disabilities and for widows and orphans of such veterans; 1870 & 1873, laws

authorized retirement pay for military officers after 30 years, at President's discretion. (1882 law made non-disability retirement mandatory at age 64.); 1885, provided non-disability retirement for enlisted personnel; and 1890, Disability Pension Act provided pensions for all veterans who had served 90 days or more and were unable to perform manual labor, regardless of whether disability was service-connected.

- 1869 - First State Board of Health established (Massachusetts).
- 1873 - First hospital census listed 178 institutions. (In 1961, AHA listed 6,923 hospitals).
- 1873 - Bellevue Hospital, NYC, established first School of Nursing.
- 1878 - Foreign Quarantine Act—to prevent the introduction of contagious or infectious diseases into the U.S. An 1890 Act related to interstate transmission of communicable diseases.
- 1883 - Germany (under Bismarck) institutes National Medical Insurance Plan.
- 1884 - Appropriations Act provided for medical care for military dependents; Federal expenditures for medical care for military and veterans dates from 1700s.
- 1887 - Dawes Act, relating to Indian lands, provided for some assistance in settling on reservations.
 - Creation of "The Hygienic Laboratory" (forerunner to NIH).
- 1894 - School health program inaugurated in Boston to control communicable diseases.

1901-1920

Income Maintenance

Social Insurance

- 1902 - First State Workmen's Compensation Law enacted (Maryland); declared unconstitutional in 1904.
- 1908 - Workmen's Compensation systems for civilian Federal employees established. (Law re-enacted in 1916.)
 - Federal Employers Liability Act covered claims for work injuries in various industries, including railroads.
- 1911 - First Workmen's Compensation law to be held constitutional was enacted.
 - First contributory pension system covering all State employees established (Massachusetts).
- 1920 - Civil-service retirement and disability fund established for Federal employees.
 - Merchant Marine Act (Jones Act), governing seamen's claims for work injuries due to negligence.

Public Assistance

- 1911 - First State laws for "mothers' aid" (forerunner of Aid to Dependent Children) (Missouri, Illinois).
- 1914 - First State law providing old-age pensions (Arizona); abolished almshouses and provided pensions for aged persons, persons incapable of self-support because of physical infirmities, and certain mothers with children; the State Supreme Court declared the law unconstitutional in 1916.
- 1915 - First old-age pension legislation (Territory of Alaska) not challenged on grounds of constitutionality enacted.

Private Sector

Settlement house movement gained influence along with other reform efforts.

- 1910 - See Montgomery Ward Plan (Health Care Delivery).

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- 1918 - Creation of Teachers Insurance and Annuity Association (TIAA)—contractual, contributory, and portable vested annuities for university, college, and independent school teachers.

Health Care Delivery

Social Insurance

- 1912 - Progressive Party (Theodore Roosevelt) platform included National Health Insurance.
 - First Child Hygiene Division established in a State Department of Health (Louisiana).
- 1916 - AMA endorsed compulsory State-run health insurance. (Position later modified.)

Private Sector

- 1910 - Montgomery Ward Company group health, life, and accident insurance program established.
- 1918 - Flexner Report led to establishment of Joint Committee on Accreditation of Hospitals (JCAH).

Other Related Developments

- 1902 - Biologics Control Act.
 - 1906 - Pure Food and Drug Act.
 - 1907 - First Federal employment service (forerunner of the U.S. Employment Service) created in the Bureau of Immigration and Naturalization, Department of Commerce and Labor.
 - 1909 - Conference on the Care of Dependent Children held in Washington, DC, at the invitation of President Theodore Roosevelt. This is the first of the White House Conferences on Child Welfare, held at approximately 10-year intervals.
 - 1911 - British National Health Insurance program enacted (limited, need-based program).
 - 1912 - Public Health Service formally created (consisted largely of former Marine Hospital Service).
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- U.S. Children's Bureau established to investigate and report on all matters pertaining to children's welfare.
- 1913 - Federal income tax begins.
- 1917 - First State Department of Welfare established (Illinois).
- War Risk Insurance Act provided for care of disabled soldiers (as well as sailors, marines, and seamen) at Marine hospitals. Law modified in 1919 to include all returning veterans. 1916-1920 legislation also modified military retirement programs, including selection out "age-in-grade" features.
- 1918 - First Federal grants made to States for public health services for prevention and control of venereal diseases.
- 1920 - Act to provide grants to States for vocational rehabilitation of persons disabled in industry or otherwise and to promote their return to civil employment. A temporary measure made permanent by the Social Security Act of 1935.

1921-1930

Income Maintenance

Social Insurance

- 1927 - Longshoremen's and Harbor Workers' Compensation Act (Federal) enacted. By 1930, all but four States had Workers Compensation programs.

Public Assistance

Federal expenditures for assistance for FY 1929 were less than \$30 million (not counting some \$571 million for veterans).

Private Sector

- 1921 - Tax law provided exemption for employer contributions to trusts, profit-sharing, or stock option plans. Similar provision for qualified pension trust under 1926 law.
- 1921 - First group annuity contract in the U.S. issued by Metropolitan Life Insurance Company.
- 1928 - Revenue Act required funding for prior services credits to be allocated over at least a 10-year period.

Health Care Delivery

Social Insurance

- 1921 - Sheppard-Towner Federal Maternity and Infancy Act provided Federal grants to States to promote maternal and infant welfare and hygiene. Expired June 1929. (Previously private groups maintained baby-health stations in many major cities.)

Public Assistance

For FY 1929, Federal outlays for health and hospital programs amounted to some \$100 million, principally for veterans (\$47 million) and Defense Department programs (\$29 million), but also including other programs:

- \$1.3 million: Indian health
- \$1.2 million: Maternal and child health (under 1921 Act)
- \$0.2 million: Workers Comp (medical)
- \$0.1 million: Medical Vocational Rehabilitation

Private Sector

- 1929 - Baylor University Hospital formalized its prepaid Group Hospitalization Plan (a precursor of Blue Cross).
- 1929 - First medical Cooperative Community Hospital Clinic (Elk City, Oklahoma).

Other Related Developments

- 1921 - Snyder Act provided substantive law for numerous Bureau of Indian Affairs activities, including "relief of distress and conservative of health."
- 1922 - Veterans Bureau (predecessor to Department of Veterans Affairs) created. Bureau given 57 former PHS/Marine hospitals and responsibility for care of Veterans.
- 1926 - Beginning of renewed efforts of Bureau of Indian Affairs to meet Indian health needs.
 - Throughout 1920s and early 1930s, there was further legislation relating to military retirement and veterans benefits.

1931-1934

Income Maintenance

Social Insurance

- 1932 - Reconstruction Finance Corporation empowered to make loans to States to combat mounting unemployment.
- 1932 - First State Unemployment Insurance Law (Wisconsin).
- 1933 - Federal Emergency Relief Act (FERA) provided direct Federal grants to States for unemployment relief.
- 1934 - June 27—Railroad Retirement Act signed. Declared unconstitutional May 6, 1935.

Public Assistance

- 1932 - First Federal loans/grants to pay for work relief and direct relief.
 - By beginning of 1935, 30 states had some form of old age pension law; 27 provided cash assistance to the blind; all had "mothers' aid" laws.

Private Sector

- 1933- - Securities Act of 1933 and Securities and Exchange Act of 1934
- 1934 1934 required pension trusts funded in part by employee contributions which purchase stock of an employer company or affiliates to register and file annual financial reports.

Health Care Delivery

Social Insurance

Following end of Sheppard-Towner Act, States first increased, then sharply reduced, funding for maternal and child health. Thirty-five states spent less in 1934 than they had in 1928; nine states discontinued special funding.

Public Assistance

- 1933 - FERA provided for emergency medical care for needy persons and for distribution of surplus or price-supported agricultural commodities to the needy.

Private Sector

- 1933 - Private hospital insurance endorsed by American Hospital Association (AHA) led to establishment of Blue Cross, which grew from 1 plan enrolling 2,000 in 1933 to 90 plans enrolling over 25 million in 1948.

Other Related Developments

- 1932 - Report of (private) Committee on the Costs of Medical Care recommended broader access to health care, reorganization of the system— group practice for physicians, and private health insurance for patients.
- 1933 - Wagner-Peyser Act established new U.S. Employment Service and provided Federal grants to States who affiliated their employment services with the U.S. Employment Services.
- 1934 - Indian Reorganization Act broadened existing programs for Native Americans.
- 6/34 - Committee on Economic Security created by President Roosevelt to study problems of and recommend legislation on economic security.

1935

Income Maintenance

Social Insurance

- Social Security (SS) (PL 74-271) Act provided: monthly old-age benefits at age 65 for insured workers in business and industry, starting 1942; certain lump sum payments; payroll tax schedules.
- SS Act also provided for Federal Unemployment Tax and grants to States for Unemployment Compensation Administration.
- Railroad Retirement Act (see also 6/37) included old-age pension and total and permanent disability pensions based on 30 years of service or an age of 60.

Public Assistance

- PL 74-721 provided Federal matching for State Old Age Assistance (OAA), Aid to the Blind (AB), and Aid to Dependent Children (ADC) programs.

Health Care Delivery

Social Insurance

- SS Act provided Federal funding for State Maternal & Child Health (MCH) programs and Crippled Children (CC) services. All States participating in MCH by end of 1936.

Public Assistance

- Federal aid to meet health care costs available only to the extent such costs were included in individual grants under ADC, OAA, or AB.

Other Related Developments

- 1/17 Committee on Economic Security Report transmitted to Congress with recommendations for Federal old-age insurance; Federal-State public assistance and unemployment insurance programs; extension of public health, maternal & child health, services for crippled children, child welfare services, and vocational rehabilitation.

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- April - Emergency Relief Appropriation Act created the Works Progress Administration (WPA) (later Work Projects Administration), Resettlement Administration, and the National Youth Administration to administer emergency work relief programs for the unemployed.
 - June - Committee on Economic Security *Risks to Economic Security Arising out of Illness* report submitted, not sent to Congress. President appointed Interdepartmental Committee to Coordinate Health & Welfare Activities created.
 - August - SS Act also established child welfare services program and expanded and made permanent the vocational rehabilitation programs enacted 6/2/20. SS Act also enlarged Public Health Service (PHS) role by providing grants in aid to help establish and maintain State and local public health agencies.
 - 1935 - Agricultural Act replaces surplus commodity program under 1933 FERA.
 - 1935- - First National Health Survey.
 - 1936

1936-1937

Income Maintenance

Social Insurance

- 3/36 - Social Security Board certified first Federal grant to administer State Unemployment Insurance law (New Hampshire).
- 8/36 - Unemployment benefits first paid under the Wisconsin law.
- 5/37 - U.S. Supreme Court upholds constitutionality of the old-age and unemployment insurance provisions of the SS Act.
- 6/37 - Railroad Retirement Act of 1937, amending portions of the 1935 Act, which had been challenged in the lower courts.

Public Assistance

- 2/36 - First public assistance payments under the SS Act in old-age assistance (17 States), aid to dependent children (10 States), and aid to the blind (9 States).

Health Care Delivery

Private Sector

- 1936- - Development of commercial surgical and medical insurance contracts.
- 1940
- 1937 - Formation of GHA of Washington, DC.

Other Related Developments

- 1937 - Increased PHS funding for State/local public health with emphases on both special programs (e.g., TB & pneumonia) and basic health needs.

1938

Income Maintenance

Social Insurance

- Jan - Unemployment benefits first payable in 22 States.
- June - Railroad Unemployment Insurance Act approved.

Public Assistance

- Dec - All 51 jurisdictions paying old-age assistance under approved State plans.

Private Sector

Revenue Act of 1938 established "non-diversion rule" requiring pension trusts to be irrevocable and used only for the benefit of employees.

Other Related Developments

- Dec - The Advisory Council on Social Security issued its report and recommendations for increasing the early adequacy and effectiveness of the social security program largely reflected in 1939 amendments.
- 1938 - Fair Labor Standards Act (PL 75-718) established Federal Standards for minimum wages, overtime pay, and employment of children.
- 1938 - Army Officer retirement legislation provided for nondisability retirement after 20 years commissioned service. (Similar legislation for Navy and Marines in 1946.)

1939

Income Maintenance

Social Insurance

- SS Amendments (PL 76-379) revised SS Program to include monthly benefits for dependents and survivors of male workers; revised benefit computations; monthly test of retirement, effective 1940.
- Jan - Unemployment benefits became payable in 26 additional States, bringing total number paying to 49; all 51 jurisdictions by July 1939.
- July - Unemployment benefits first payable under the Railroad Unemployment Insurance Act.
- Federal Unemployment Tax Act (FUTA) PL 76-379 moved tax provisions to the Internal Revenue Code.

Public Assistance

- SS Amendments increased ADC matching from one-third to one-half; increased maximum child age from 16 to 18 years; and increased Federal matching in OAA and AB programs.

Health Care Delivery

Social Insurance

- SS Amendment expanded funding for MCH and CC programs. All States participating in CC program.

Other Related Developments

- 1934- - First" Food Stamp program, administered by the Department of
1939 1939 Agriculture. (See 1961 for "second" (current) Food Stamp program.) Department of Agriculture also administered surplus commodities program, beginning 1936.

1940-1942

Income Maintenance

Social Insurance

Social Security (SS) legislation, 1940-1945, consisted of relatively small changes in SS coverage and adjustments in tax schedules.

- 1/40 - First monthly benefits payable under old-age and survivors insurance to aged retired workers, their dependents, and survivors of deceased insured workers.
- 1942 - Rhode Island adopts first State Temporary Disability Insurance (TDI) program, effective 1943, requiring employers to provide short-term coverage of wage loss from illness or injury, financed by employer and employee tax contributions.
- 1942 - Temporary Civilian War Benefits Program provided wage-loss benefits for civilians for temporary total or permanent partial disability resulting from enemy action.

Public Assistance

- 1942 - Temporary Civilian War Assistant program provided aid to civilians affected by enemy action. Emergency grants to States for day care services.

Private Sector

- 1942 - 1940s saw growth in private pension plans, due to effects of wartime wage freeze and excess profits tax. Revenue Act of 1942 revised tax preference provisions so that: funds must be irrevocably committed to benefits; plans must not discriminate in favor of higher-paid workers; and there are upper limits on deductions.

Health Care Delivery

Social Insurance

- 1942 - (President Roosevelt proposed hospital (and disability) insurance under social security.)

Public Assistance

- 1942 - Emergency Maternity and Infant Care (EMIC) provided grants for health services to dependents of servicemen in the lower four pay grades, administered by Children's Bureau through local health agencies. Program terminated 6/30/49.

Other Related Developments

- 1942 - Servicemen's Dependents Allowance Act of 1942 enacted; provided family allowances for dependents of enlisted men in the four lowest pay grades of the Armed Forces.
- 1942 - Revenue Act provided for individual deduction of unreimbursed health care costs above specified unit.
- 1942 - Publication, in Great Britain, of Beveridge Report "Social Insurance and Allied Services".

1943-1944

Income Maintenance

Social Insurance

- 1944 - SS Act amended to authorize appropriation of any additional amounts required to finance benefits and payments from general Treasury funds to the old-age and survivors insurance trust fund. Repealed in 1950.
Servicemen's Readjustment Act of 1944—popularly known as the GI Bill of Rights—provided for expansion of hospital facilities; education and training allowances; guaranty of loans for aid in acquiring or constructing homes, farms, or business property; special placement services through the U.S. Employment Service; and readjustment allowances while veterans find employment.
- 10/44 - War Mobilization and Reconversion Act established Federal unemployment account in the unemployment trust fund whence States might borrow—up to July 1947—when their own unemployment funds fell to a certain level.

Health Care Delivery

Social Insurance

- 6/43 - Original Wagner-Murray-Dingell Bill for comprehensive health insurance under Social Security introduced.

Private Sector

- 1943 - IRS ruled that employer contributions to group health insurance were not taxable to employee. Policy stated in law since 1954, modified in 1986.

Other Related Developments

- 7/43 - Program of grants in aid for Vocational Rehabilitation of the Handicapped expanded, removed from SS Act, medical services included.

7/44 - Public Health Service (PHS) Act consolidates legislation relating to PHS.

1945-1946

Income Maintenance

Social Insurance

- 1946 - SS Act Amendments of 1946 provided benefits for survivors of certain World War II veterans who die within three years of discharge from military service, covered private maritime employment under State Unemployment Insurance laws; provided a temporary Federal program for unemployment benefits to seamen whose wartime employment was technically Federal, and allowed States that had collected employee contributions under State unemployment insurance laws to use the money to finance disability insurance benefits.
- California adopted Temporary Disability Insurance (TDI) plan, including hospital benefits.
 - 1946 Amendments to the Railroad Retirement and the Railroad Unemployment Insurance Acts provided for cash sickness and maternity benefits (temporary Disability insurance), occupational disability benefits, and the coordination of certain survivor benefits with SS survivor benefits. Also reduced service requirements and increased some pension amounts.

Health Care Delivery

Social Insurance

- 11/45 - President Truman sends Health Message; Revised Wagner-Murray-Dingell bill introduced.
- 5/46 - Taft et al. propose grants to States for medical care for the poor.

Private Sector

- 1945 - AMA began promoting medical care plans under aegis of local medical societies, spurring growth in Blue Shield plans.

Other Related Developments

- 1946 - Creation of Centers for Disease Control (CDC) in Atlanta (from World War II Malaria Control Program).
- Hill-Burton Hospital Survey and Construction Act provided Federal funds for hospital construction; required development of health planning agencies.

1947-1949

Income Maintenance

Social Insurance

- 4/48 - Workmen's Compensation legislation became nationwide with Mississippi's enactment of such a law.
- 1948 - New Jersey TDI plan adopted.
- 1948 - Civil Service Retirement System amended to include survivor benefits.

Private Sector

- 1948 - Labor Management Relations Act of 1947 (Taft-Hartley) included requirement that union-management pension agreements be written, their funds used only for benefits, and both sides equally represented in their operation.
- 1949 - Supreme Court decision affirming National Labor Relation Board's 1947 interpretation of NLRA that employers must agree to include pensions in collective bargaining.
- 1949 - The Steel Industry Fact-Finding Board held that employers were obligated to provide workers with pensions and other welfare benefits.

Health Care Delivery

Private Sector

- 1949 - NLRB decision, affirmed by U.S. Court of Appeals, allowing inclusion of industry-financed health insurance as a fringe benefit subject to collective bargaining.

Other Related Developments

- 1948 - Advisory Council on Social Security presented its reports, with recommendations on public assistance, old-age and survivors insurance, disability insurance, and unemployment insurance, to the Senate Finance Committee.

1949 - Career Compensation Act provided military retirement benefits after 20 years with pension based on final pay and length of service (maximum = 75 percent of pay). Disability benefits available based on 30 percent or greater disability.

1950-1951

Income Maintenance

Social Insurance

- 1950 - Major SS Amendments (PL 81-734) expanded SS coverage to farm and domestic employment; nonfarm self-employed (except professional groups); provided World War II gratuitous military service, wage credits; provided benefits for dependents and survivors of women workers; increased benefits by more than 75 percent; provided new computation method; revised financing schedule; and authorized advances of unemployment funds to States through 1951.
- 1951 - Railroad Retirement benefits increased substantially; greater coordination with SS.

Public Assistance

PL 81-734 also:

- Added Federal matching for Aid to the Permanently and Totally Disabled (APTD).
- Included child's caretaker/relative in AFDC grants.
- Provided \$50 earnings disregard for blind.
- Provided vendor payments for medical care.

Health Care Delivery

Social Insurance

- 1950 - SS Amendments included major increases in funding for MCH and CC programs.

Public Assistance

- 1950 - SS Amendments also provided for vendor payments for medical care/supplies up to fixed limits and for Federal participation in costs of payments to the Aged, Blind, or Disabled in public medical institutions other than for TB or mental disease.

Private Sector

1950 - National Association of Insurance Commissioners adopts model "uniform policy provisions," to deal with conflicts and confusion caused by variety of available health plans.

1952-1955

Income Maintenance

Social Insurance

- SS legislation generally included further extensions of coverage, including many professional self-employed and State and local employees under a retirement age law (group elective); adjustments in benefits computations and financing in light of wage and price increases.
- 9/54 - First major extension of the coverage of the Federal Unemployment Tax Act approved: employees of firms employing 4 or more in 20 weeks, after 1 January 1956.
- 1954 - SS Act amended by addition of new Title XV to provide unemployment insurance benefits for Federal civilian employees financed by Federal funds and paid by State agencies under their own benefit formulae.
- 1955 - Railroad Retirement amendments provided benefits for disabled children of deceased railroad workers. Subsequent railroad legislation through early 1960s updated benefit amounts and survivor provisions.

Public Assistance

- 1953 - With approval of Nevada's plan for Aid to the Blind, all 53 jurisdictions administered such programs.
- 1955 - Nevada began Aid to Dependent Children; all 53 jurisdictions now administer such programs.

Health Care Delivery

Social Insurance

- 1954 - (Eisenhower proposes "reinsurance" approach for meeting health insurance needs of high-risk groups.)

Private Sector

- 1954 - The Federal Trade Commission (FTC) cited numerous prominent companies for false and misleading advertising of

health insurance policies, by its authority under the Insurance Regulation Act. This led to States' rules governing such advertising and to the Supreme Court limiting FTC authority.

Other Related Developments

- 7/52 - Veteran's Readjustment Assistant Act temporarily provided for unemployment compensation for veterans under Federal formulae but subject to State availability and disqualification provisions. Permanent provision adopted in 1958.
- 1953 - Uniformed Services Contingency Option Act provided survivor option for military and other Uniformed Services.
- 8/54 - PL 83-568 transferred responsibility for Indian health from BIA (Interior Dept.) to PHS; subsequently (see 1976), Indian Health Service created to provide comprehensive health services for American Indians and Alaska Natives.
- 1954 - Internal Revenue Code of 1954 re-included earlier pension-related provisions of the 1928, 1938, and 1942 Acts. Also, established 3 percent of AGI threshold for deduction of unreimbursed health expenditures; increased to 5 percent in 1982 TEFRA and 7.5 percent in 1986 Tax Reform.
- 1954 - Vocational Rehabilitation Act amended to call for cooperation of vocational rehabilitation agencies with State public assistance agencies, the Bureau of Old-Age and Survivors Insurance, and other public agencies providing services related to vocational rehabilitation services.
- 1954 - Major expansion of Hill-Burton legislation to include chronic disease hospitals, nursing homes, rehabilitation centers, and modernization of existing hospitals.

1956-1957

Income Maintenance

Social Insurance

- 1956 - SS Amendments provided benefits for permanently and totally disabled workers aged 50+ and disabled adult children of retired or deceased workers. Coverage extended to members of armed services and remaining self-employed (other than MDs). Old-age benefits made available to women at age 62, with benefits for wives and women workers actuarially reduced if claimed before age 65.

Public Assistance

- 1956 - SS Amendments further increased Federal matching share; linked services with public assistance payments; eliminated school requirement for ADC for children age 16 to 18 years, and otherwise expanded eligibility; and provided for grants/contracts to study dependency issues.

Health Care Delivery

Social Insurance

- 8/57 - (Original Forand bill for Health Insurance for Social Security beneficiaries introduced.)

Public Assistance

- 1956 - SS Amendments eliminate limitation on vendor payment matching related to individual payments. Provides \$1 for \$1 Federal matching for vendor payments, subject to specified maximum matching.

Other Related Developments

- 1956 - SS Amendments strengthened and expanded Child Welfare Services under Title V of SS Act.
- 6/56 - PL 84-569, Dependent's Medical Care Act ("medicare") program enacted. Provided health benefits for dependents of members of Uniformed Services (later "Civilian Hospital and Medical Program of the Uniformed Services"—CHAMPUS).
- 8/56 - PL 84-881, Servicemen's and Veterans' Survivor Benefits Act, provided for 6-month death payment, dependency and indemnity compensation (DIC) for widows and children, and for full SS coverage of military personnel.

1958-1959

Income Maintenance

Social Insurance

- 1958 - SS Amendments provided benefits for dependents of disabled workers.
- 6/58 - Temporary Unemployment Compensation Act provided for advancing funds to States to pay extended unemployment compensation to workers who have exhausted State benefits, through 3/59. (1961 legislation extended this measure through 1962.)

Private Sector

- 1958 - Welfare and Pension Plans Disclosure Act required annual disclosure to participants and beneficiaries of financial and other information relating to Plan operations.

Health Care Delivery

Social Insurance

- 1959 - Federal Employees Health Benefits Act.

Other Related Developments

- 8/58 - Ex-Servicemen Unemployment Compensation Act made permanent provision for unemployment compensation, similar to arrangements for Federal civilian work force.
- 9/58 - PL 85-857 consolidated veterans legislation in title 38 U.S.C. (Further codification/redesignations made in 1991, PL 102-83.)
- 1959 - Veterans Pension Act (PL 86-211) established pension rates based on broad income brackets.

1960-1961

Income Maintenance

Social Insurance

- 1960- - SS Amendments provided simplified computation; increased
- 1961 widow(er) benefits; reduced available benefits for men at age 62; eliminated age 50 requirement for disabled workers.
- 1960 - Unemployment insurance coverage extended to additional Federal and nonprofit employees; Puerto Rico included in system.
- 1961 - Legislation to provide temporary extended unemployment benefits.

Public Assistance

- 1961 - Provided temporary Federal matching for Aid to Children with an Unemployed Parent (UP). Also provided temporary program of Assistance to Repatriated Americans (Refugee Resettlement).

Health Care Delivery

Social Insurance

- 1961 - King-Anderson Bill introduced—Administration proposal for hospital and medical insurance for the aged, financed through FICA taxes.

Public Assistance

- 1960 - SS Amendments provided for Federal matching program of Medical Assistance for the Aged (MAA) (including the "medically indigent"); Kerr-Mills legislation. (Optional alternative to Vendor-payment system.)

Other Related Developments

- 1961 - Food Stamp program established on a "pilot basis." (Made permanent in 1964.)
- White House Conference on Aging endorsed health insurance through SS taxes.
- Community Health Services and Facilities Act included provision for Federal grants to State and local community agencies for developing methods to provide out-of-hospital services, particularly for the chronically ill and the aging.

1962-1963

Income Maintenance

Public Assistance

- 7/62 - PL 87-543, Public Welfare Amendments of 1962—designed to improve services to reduce or prevent dependency; extended AFDC-UP for 5 years; provided for community work and training programs; increased funds for adult assistance categories; increased Child Welfare Services funds (including day care). Also provided optional single adult assistance category (Title XVI) and for disregard of earnings-related expenses in all assistance categories; extended repatriation program for 2 years; and provided for waiver demonstration programs (Section 1115).

Private Sector

- 1962 - Self-Employed Individuals Tax Retirement Act providing tax incentives for self-employed persons, "Keogh" plans.
- 1962 - Welfare and Pension Plans Disclosure Act Amendments strengthened authority of Secretary of Labor to ensure compliance.
- 1963- - Securities and Exchange Commission ruled that tax-qualified
1964 group pension plans (including variable annuities) were exempted from registration and prospectus requirements of the Securities Act. (See 1933-34.)

Health Care Delivery

Private Sector

- 1962 - American Hospital Association withdrew opposition to compulsory hospital insurance under SS if program administered via private organizations (e.g., Blue Cross).

Other Related Developments

- 1963- - Legislation for mental retardation and community mental
- 1965 health centers (phased out beginning 1974).

1964-1965

Income Maintenance

Social Insurance

- 7/65 - SS Amendments, PL 89-97 included general benefit increase, students' benefits, benefits for divorced spouses, and minimum benefit increases (to accommodate SMI premium); liberalized disability program including requirement that disability be expected to last at least 1 year or end in death (rather than be permanent). Also, coordinated SS and RR tax provisions.

Public Assistance

- 7/65 - SS Amendments increased Federal matching if passed through in higher public assistance payments; permitted matching for needy aged in mental or TB institutions (subject to State actions); extended AFDC up to age 21 if child in school; liberalized earnings disregards.

Health Care Delivery

Social Insurance

- 7/65 - Enactment of Medicare: (PL 89-97) Hospital Insurance (financed by payroll tax) and Supplemental Medical Insurance (financed by enrollee premiums and general revenues) for aged SS beneficiaries and certain noninsured persons.

Public Assistance

- 7/65 - Enactment of Medicaid, providing Federal matching for State aid to all categorically needy persons (a major expansion of the Kerr-Mills program). Authorized Federal matching for medically needy persons.

Private Sector

Medicare administered through private carriers and intermediaries.

Other Related Developments

- 1964 - Food Stamp Act provided food stamps purchased by participants with price based on household income.
- 1964 - Title VI of PL 88-352, the Civil Rights Act, barred racial discrimination in federally assisted programs.
- 1/65 - Report of 1963-1965 Advisory Council on Social Security recommended hospital insurance for the aged under SS.
- 7/65 - SS Amendments also provided tax deduction for one-half of health insurance premiums (repealed in 1968) remainder of premiums, plus SMI premiums, includable in medical expenses. Repealed maximum limits on medical expenses of disabled.
- 1965 - Neighborhood Health Centers program launched.
 - Established Regional Medical program (abolished in 1973-74).
 - Age Discrimination in Employment Act permitted mandatory retirement at age 65.
- 1965 - The President's Committee on Corporate Pension Funds and Other Private Retirement and Welfare Programs Issued its report, "Public Policy and Private Pension Programs." This was the forerunner of ERISA (1974)

1966-1971

Income Maintenance

Social Insurance

- 1966 - First in a series of "temporary" railroad retirement system provisions for supplementary benefits, leading to the 2-tier structure created in 1974.
- 1967 - (Signed 1/68). SS Amendments further increased SS benefits, extended benefits to disabled surviving spouses.
- 1969 - Federal Coal Mine Health and Safety Act provided cash "Black Lung" benefits for miners disabled with pneumoconiosis and their widows and qualified dependents. Pre-1974 claims financed from general revenues.
- 1969- - SS benefit increases enacted
- 1971
- 1970 - FUTA coverage extended to small businesses, non-profits, higher education (PL 91-373).
- 1970- - Railroad Retirement benefits substantially increased.
- 1972
- 1971 - Beginning of another series of temporary extended unemployment benefits legislation.

Public Assistance

- 1967 - IRS to cooperate in efforts; to locate absent parents of AFDC recipients.
 - AFDC earnings disregard of \$30 per month and one-third of remainder; established Work Incentive Program (WIN).
- 1968 - Administration proposed "Family Assistance Plan" (FAP).
- 1969 - Supreme Court found State residency requirements unconstitutional.

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- 1971 - Legislation required AFDC recipients to register for manpower services. Optional AFDC-UP program modified and extended.

Health Care Delivery

Public Assistance

- 1967 - Amendments provided for Medicaid buy-in for public assistance recipients age 65 and older (State may include medically needy only); experimentation with alternate reimbursement methods; Medicaid coverage for Intermediate Care Facility (ICF) services.

Private Sector

Beginning of "Medigap" insurance policies covering deductibles, coinsurance, and services not covered by Medicare.

Other Related Developments

- 1966 - Comprehensive Health Planning and "Partnership for Health" program.
- 1/68 - SS and Medicare Trust Fund transactions first shown in Unified Budget.
- 12/68 - Report of statutory Advisory Council on Health Insurance for the Disabled. Many proposals included in 1972 amendments extending Medicare to disabled SS beneficiaries.
- 1970 - National Health Service Corps enacted.
- 1971 - Quadrennial Advisory Council on SS report. 1972 legislation reflects many recommendations, including automatic COLAs, use of dynamic economic assumptions, and current cost financing.
- 1971 - Food Stamp legislation dropped purchase requirement in some cases, based allotment on cost of nutritionally adequate diet, added work requirements.

1972

Income Maintenance

Social Insurance

- PL 92-336, included 20-percent SS benefit increase, as well as automatic adjustment of future benefits to prices and of the future tax base to wages.
- PL 92-603, numerous liberalizations in SS benefits and eligibility; extensions of coverage; revised financing schedules.
- Black Lung Benefits Act of 1972 extended coverage and added benefits for surviving children; Department of Labor given jurisdiction for post-1973 cases.

Public Assistance

- PL 92-603 established Federal SSI program (with State supplementation) (effective 1/1/74) in place of Federal-State Assistance programs of OAA, AB, and APTD in the 50 States, with uniform Federal eligibility criteria and payment levels.

Health Care Delivery

Social Insurance

- PL 92-603 extended Medicare coverage to disabled SS and RR beneficiaries and to certain persons with end-stage renal disease (effective 7/73); established utilization review program, Professional Standards Review Organization; and clarified Extended Care Facility coverage, redesignated as Skilled Nursing Facility. Administrative limits on reasonable costs, physicians fees, and capital reimbursement.

Other Related Developments

- Establishment of WIC Program—Supplemental Food for Women, Infants, and Children.
- During the period of wage/price restraints early 1970s (late 1971-74), the Price Commission issued guidelines which limited health care

price increases; e.g., physician fee increases were limited to 2.5 percent per year.

- Military survivors benefit plan replaced the family protection plan; general revenue subsidy provided; some integration with SS benefits.

1973-1974

Income Maintenance

Social Insurance

- 1973 - Amendments provided *ad hoc* benefit increases prior to automatic COLA provisions.
- 10/74 - PL 93-445, Railroad Retirement Act of 1974, provided new, two-tier approach—Tier I analogous to SS; Tier II based exclusively on railroad service—phased out concurrent receipt of SS and RR benefits.

Public Assistance

- 1973 - Legislation increased Federal SSI benefit rate, modified transition provision.
- 1974 - SSI legislation provided for automatic COLAs and reimbursement to States for interim assistance for eligible persons.

Private Sector

- 1974 - Employee Retirement Income Security Act of 1974 (ERISA) established minimum standards for participation, vesting, and funding of private plans (pre-exempting State insurance laws); strengthened fiduciary standards and reporting and disclosure provisions; established Pension Benefit Guarantee Corporation (PBGC) to, in effect, reinsure defined benefit plans; provided tax deduction for Individual Retirement Accounts (IRAs) for noncovered workers. Also established rules for tax treatment of "Cafeteria Plans." (Modified in 1978 and 1986.)

Health Care Delivery

Social Insurance

- 1974 - MCH, CC, and administrative funds for State Public Health Agencies included in Block Grant.

Private Sector

- 1974 - Many ERISA provisions (see above) also apply to employee health insurance plans, preemption is ambiguous with respect to insured health plans, which remain subject to some State regulation—see 1985 Metropolitan Life case.

Other Related Developments

- 1973 - Legislation expanded Food Stamp program, broadened eligibility, and phased out the Family Food Distribution Program.
- 1973 - PL 93-82, Veterans Health Care Expansion Act, established; CHAMPVA (Civilian Hospital and Medical Program of the Veterans Administration for civilian dependents and survivors of veterans).
- 1973 - Rehabilitation Act (PL 93-112) provided comprehensive vocational rehabilitation services, replacing Vocational Rehabilitation Act of 1954.

1975-1976

Income Maintenance

Social Insurance

1975 - The Supreme Court ruled, in Weinberger v. Wiesenfeld, that SS benefits must be provided for a widowed father on the same bases they were available to a similarly situated women. Subsequent decisions by Federal and district courts as well as Supreme Court stuck. Other gender-based distinctions; e.g., 1977 decisions in California v. Goldluck and California v. Silborwitz, related to husband's and widower's benefits. Statute modified 1977 and 1983.

10/76 - PL 94-566, Unemployment Compensation Amendments of 1976, extended coverage to State and local government workers and certain agricultural and domestic labor; Imposed 0.2 percent temporary surtax in addition to permanent 0.6 percent tax; and required States to offset compensation for receipt of public or private pensions (modified in 1980).

Public Assistance

1975 - PL 93-647 created Child Support Enforcement program; provided Federal matching funds to enforce support obligations of noncustodial parent of child eligible for AFDC; established Federal parent locator service; authorized garnishment of Federal benefits (including SS) to enforce support or alimony orders; required interstate cooperation in enforcing support orders.

Private Sector

1975- - SSI legislation included numerous minor liberalizations,
1979 adjustments in relationships to other programs, and technical modifications.

Health Care Delivery

Social Insurance

- 1970s saw substantial growth in Medical and hospitalization payments made under State workers compensation plans.

Other Related Developments

- 3/75 - Quadrennial Advisory Council on SS report included recommendations for revised SS benefit structure similar to 1977 Amendments.
- 1/75 - PL 93-641, Health Planning & Resources Development Act—superseded Regional Medical Planning, Comprehensive Health Planning, and Hill-Burton programs—established area-wide health planning agencies to increase access to and quality of services, restrain costs, prevent duplication, etc.
- 3/75 - PL 94-12, Tax Reduction Act of 1975, provided for Earned Income Tax Credit (EITC) to offset SS tax for workers with children. EITC modified and made permanent in 1978.
- 1976 - PL 94-437, Indian Health Care Improvement Act, strengthened Indian health services.

1977

Income Maintenance

Social Insurance

- 12/77 - PL 95-216, SS Amendments modified COLA provisions, stabilized replacement rates through wage-indexed computation, revised tax schedule, and made numerous other changes.
- 1970s - Throughout the decade there was substantial growth in State workers compensation payments in relation to covered payrolls (following 2 decades or relatively little growth).

Health Care Delivery

Social Insurance

- PL 95-142, Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977, required Study and Report which led to 1980 (PL 96-499) changes.

Public Assistance

- PL 95-142 provided for Medicaid agency to use CSE agency to enforce medical support rights.

Other Related Developments

- 9/77 - PL 95-113, Food and Agriculture Act of 1977, modified Food Stamp program by eliminating purchase requirements, standardizing allowable deductions from income, setting eligibility at OMB poverty guidelines, and requiring SSI and AFDC recipients to meet asset, income, and work requirements.

1978-1979

Income Maintenance

Social Insurance

- 1978 - PL 95-239, Black Lung Reform Act of 1977, and PL 95-227 made Part C (future claims) provisions permanent and established a Black Lung Trust Fund, with claims to be paid thereby or by the responsible employer. Medical and rehabilitation benefits also available to workers under part C.
- 1978 - Revenue Act provided for including part of UC in taxable income (100 percent included under 1986 Tax Reform Act).

Private Sector

- 1978 - Revenue Act provided for qualified cash or deferred income arrangements—"401(k) plans." Also, modified rules relating to cafeteria plans.

Health Care Delivery

Social Insurance

- 1978 - PL 95-272 amended the End-Stage Renal Disease Program to lower costs, avoid disincentives to transplantation, etc.

Private Sector

- 1978 - Revenue Act included provision to tax health benefits of high-income persons under self-insured health plans that did not meet nondiscrimination standards.

Other Related Developments

- 1978 - PL 95-256, Age Discrimination in Employment Act of 1978, raised from 65 to 70 the permissible mandatory retirement age.
- 11/78 - PL 95-588, Veterans and Survivors' Pension Improvement Act of 1978, revised method of figuring pension (need-based) benefits; COLAs made to coincide with SS COLAs.

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- 1978 - PL 95-600, Tax Revenue Act of 1978, modified EITC provision and made it permanent. Subsequent legislation has made further changes.
 - 1978 - PL 95-602, Rehabilitation, Comprehensive Services, and Developmental Disabilities Act.
 - 1979 - Liberalized Food Stamp eligibility requirements for the aged and the disabled.
 - 12/79 - Quadrennial Advisory Council on SS report submitted; reviewed whole SS program, especially benefit equity, treatment of women under social security, and financing. (Recommended taxation of one-half SS benefits and use of general revenues to finance Hospital Insurance.)

1980

Income Maintenance

Social Insurance

- 6/80 - PL 96-265, Disability Amendments, modified benefit computation to preclude overinsurance, enhanced administrative oversight (including continuing disability reviews and pre-effectuation reviews of State agency allowances), and added numerous work incentives (including 15-month re-entitlement period and extended Medicare protection).

Public Assistance

- PL 96-265, established a 3-year demonstration program (Section 1619, later made permanent) whereby blind or disabled SSI recipients who engaged in substantial gainful activity could nonetheless retain SSI status and Medicaid eligibility.

Health Care Delivery

Social Insurance

- PL 96-499, OBRA 1980, tightened cost controls, permitted lower payment rates for skilled nursing facilities, and liberalized care coverage.

Other Related Developments

- Provided for biennial (rather than annual) updating of Food Stamp program and restricted eligibility of students.
- Refugee Health Program established.

1981

Income Maintenance

Social Insurance

- 1981 OBRA (PL 97-35) eliminated SS minimum benefit for future, phased out "student" benefits, and otherwise modified benefits. Also temporarily authorized borrowing among the OASI, DI, and HI trust funds to help meet OASI benefit costs.
- 1981 OBRA limited payment of unemployment insurance to ex-servicemen; raised trigger for extended UC program.
- 1981 Railroad Act increased taxes, provided borrowing authority from general revenues, and modified Tier II benefits.

Public Assistance

1981 OBRA modified AFDC earnings disregard, barred payments if combined unit income exceeds 150 percent of need, required retrospective monthly accounting (for both SSI and AFDC), created optional Community Work Experience Program (CWEP).

Private Sector

- 1981 Economic Recovery Tax Act extended IRA to virtually all workers. (Limited again in 1986.)
- IRS issued preliminary regulations for 401(k)-type plans, which have since expanded significantly.
- 1981 Report of President's Commission on Pension Policy recommended Minimum Universal Pension (MUP) system.

Health Care Delivery

Social Insurance

- PL 97-35, OBRA 1981, increased hospital and medical deductibles, tightened hospital reimbursements, tightened reimbursements for renal dialysis; Medicare 2nd payer for ESRD for first 12 months; prospective payment for ESRD.

Other Related Developments

- OBRA and Food Stamp and Commodity Distribution Amendments of 1981 made numerous modifications to limit costs and improve enforcement of Food Stamp program.
- Closure of Marine Hospitals (program began in 1798).
- 1981 OBRA provided for collection of past-due child support debts by withholding income tax refunds.
- Report of (Gwirtzman) National Commission on Social Security (March 1981) recommended coverage extensions; gradual increase in retirement age; general revenue funding for one-half of hospital insurance; experimentation with physician fee schedules and prospective payment for hospitals; 25-percent increase in SSI payments and expansion of Medicaid.

1982

Income Maintenance

Social Insurance

- PL 97-455 provided for continued payment of Social Security disability payments pending appeal of cessation decision, a temporary provision made permanent in 1990.

Private Sector

- PL 97-248, TEFRA, eliminated disparate treatment of pension plans based on whether company was incorporated.

Health Care Delivery

Social Insurance

- PL 97-248, TEFRA, Federal employees covered for hospitalizations, effective 1/83; Medicare secondary for workers and spouses age 65 to 69 years; new limitations on hospital reimbursement; modified reimbursement for provider-based physicians; offered choice of competing health plans—HMO option; coverage of hospice care; revised peer review (PRO) and utilization provisions.

Other Related Developments

- 1982- - Food Stamp legislation adjusted benefits, eligibility, and
1983 enforcement provisions.
- PL 97-377 provides DoD-funded benefits in place of certain SS "student" benefits available before 1981 SS amendments.

1983

Income Maintenance

Social Insurance

- 4/83 - PL 98-21, SS Amendments of 1983, made major changes in coverage, benefits, and financing to restore financial soundness: extended coverage for SS and Hospital Insurance to Federal employees and nonprofit organization employees; precluded termination of State/local coverage; improved benefits for disabled and divorced and surviving spouses; formally eliminated gender-based distinctions; increased retirement age to 67 over the first quarter of the 21st century; delayed COLAs by 6 months; revised tax schedule; provided for taxing SS and RR Tier I benefits of higher-income beneficiaries; liberalized earnings test and increased delayed retirement credit; provided for gradual removal of SS trust funds from unified budget.
- 8/83 - PL 98-76, Railroad Retirement Solvency Act of 1983, included numerous benefit limitations and revenue increases somewhat similar to those in SS.

Public Assistance

- 4/83 - PL 98-21 increased basic SSI payment level by \$20 (\$30 for couples).

Private Sector

- 1983 - The U.S. Supreme Court decided that employee retirement benefits based on contributions made after August 1, 1983, must be calculated without regard to the sex of the employee.

Health Care Delivery

Social Insurance

- 7/83 - PL 98-21 provided prospective payment system for inpatient hospital services based on DRG system; all inpatient physicians services paid as hospital services.

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- 1980s - Growth in State concern as to persons lacking health insurance coverage costs of uncompensated care. Eager by 1985 (prior to Federal mandate in CPBRA (4/86), 23 States required continuation of health insurance coverage for unemployed workers/families.

Other Related Developments

- 1/83 - Report of National Commission on SS Reform ("Greenspan Commission") recommends measures to restore financial soundness of SS system. Recommendations substantially reflected in PL 98-21, above.

1984

Income Maintenance

Social Insurance

- 10/84 - PL 98-460, Social Security Disability Reform Amendments of 1984, provided for use of a "medical improvement standard" to determine if a person is no longer disabled and otherwise changed adjudicative processes.

Public Assistance

- 1984 - Child Support Enforcement Amendment (PL 98-378) expanded CSE program to non-AFDC families; added enforcement procedures (e.g., State liens, wage garnishment requirements); strengthened audit penalty provisions; further encouraged automated State systems; added research and demonstration provisions.
- 10/84 - PL 98-460, Modifications in SSI Disability Provisions similar to Title II, and extension of Temporary (1619) provisions for SSI payments to disabled beneficiaries who work.

Private Sector

- 8/84 - PL 98-397, Retirement Equity Act of 1984, amended IRC and ERISA to improve protection for women—Joint and Survivor options, treatment of pension rights at divorce, etc. Also reduced minimum participation age from 25 to 21 years.

Health Care Delivery

Social Insurance

- 1984 DEFRA provided for medical premium increase, physician payment freeze; established concept of participating physicians.

Public Assistance

- PL 98-378 required States to petition for Medical support in certain child support cases.
- 1984 DEFRA expanded Medicaid coverage of pregnant women and young children.

Private Sector

- 1984 - FASB "Statement 81" required employers to disclose current cost of retiree health and life insurance benefits.

Other Related Developments

- 1984 - DEFRA discouraged use of voluntary employee beneficiary associations (VEBAs) and 105(h) trust to finance retiree health plans by limiting VEBA deductible contributions, applying nondiscrimination rules, and counting investment earnings as income.
- 1984 - DEFRA authorized use of offset Federal income tax returns to collect Federal debts (other than SS)—e.g., SSI, Food Stamps, etc. (SS debts included in 1990 legislation.)
- 1984 - PL 98-525 provides new ("Montgomery") GI Bill for 3-year test period; made permanent in 1987 (PL 100-48); provided educational and training assistance for veterans.
- 2/84 - Report of (Bowen) Quadrennial Advisory Council on Social Security. This council focused largely on health issues; recommended catastrophic health insurance coverage.

1985-1987

Income Maintenance

Social Insurance

- 6/86 - PL 99-335 provided for new Federal Employee Retirement System (FERS) coordinated with SS coverage.

Public Assistance

- 11/86 - PL 99-643, Employment Opportunities for Disabled Americans Act, made permanent the provisions of Section 1619: SSI cash benefits and Medicaid coverage for persons who work despite severe impairments.

Private Sector

- 1986 - Tax Reform Act of 1986 strengthened ERISA vesting provisions; provided penalties for pre-retirement lump sum withdrawals; limited deduction for IRA to persons not covered by an employer retirement plan; and revised other tax provisions. 1987 OBRA included provisions to reduce excessive under- or over-funding of defined benefit plans.
- 1986 - Legislation (PL 99-272 and PL 100-203) included PBGC reforms; higher 1987 premiums and greater employer liability.
- 1986 - LTV Corporation's Chapter 11 bankruptcy reorganization presented major issues for PBGC (and for treatment of health benefits).

Health Care Delivery

Social Insurance

- 1986 - PL 99-272, COBRA 1985 (signed 4/7/86) and 1986 OBRA (PL 99-509) provided Medicare coverage for State and local employees hired after 1985; made Medicare secondary payer for all aged workers and spouses and for working disabled covered by employer plans; limited SMI premium to 25 percent of costs through 1988; extended existing freeze on Medicare

reimbursements; adjusted payments to hospitals to reflect "disproportionate share" of low-income patients; increased physician payment rates; improved prospective payment system to account for severity of illness; added various cost controls. Also, limited Medicare home health benefits, increased coverage for mental health and certain other services.

- 1987 - PL 100-119, Balanced Budget and Deficit Emergency Control Reaffirmation Act, provided cost and reimbursement controls, including delay of physician payment update and decreases in scheduled hospital prospective payment rates.

Public Assistance

- 10/86 - PL 99-509 made Medicaid coverage of disabled SSI recipients who work (1619b) a permanent provision and provided additional categorically needy option for persons age 65 or older or disabled with incomes and resources up to poverty level.
- 1987 - OBRA (PL 100-203) allowed expansion of programs for pregnant women and infants, coverage of child to age 7 (later mandated).

Private Sector

- 1985 - Supreme Court, in Metropolitan Life v. Massachusetts, upheld right of States to mandate employer-provided health benefits through insurance regulation function; found that ERISA "does not regulate the substantive content of welfare-benefit plans."
- 1986 - COBRA also required that employer-provided group health plans (including self-insured plans) to provide option for continuation of coverage for workers and dependents in case of layoff or for survivors if worker dies.
- 1986 - PL 99-591, a continuing appropriation bill, included (in response to the LTV bankruptcy) a temporary prohibition on curtailing retiree health benefits in such cases until May 1987. (See PL 100-334, 1988.)
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- 1986 - Tax Reform Act: general exclusion of contribution to employer-provided accident or health plan applied to coverage of former and current employees and dependents; to the extent health benefits are pre-funded, tax-favored status of asset earnings available (401(h)) where health benefits are incidental to retirement benefits. Increased threshold for individuals deducting unreimbursed health expenses to 7.5 percent of AGI.

Other Related Developments

PL 99-198, Food Security Act of 1985, liberalized benefit and eligibility provisions; modified "disability" to cover persons receiving SSI, Railroad, Veterans, or other governmental disability payments; AFDC and SSI households made categorically eligible.

- 1985 - PL 99-177, Balanced Budget and Emergency Deficit Control Act of 1985 (includes original Gramm-Rudman-Hollings Amendment), set a schedule of declining Federal deficits and provided for enforcement through sequestration; excluded SS benefits from sequester but included income and outgo in budget totals. Also excluded from sequester were benefits under SSI, AFDC, WIC, Medicaid, Food Stamps, Railroad Retirement Tier I, Unemployment and Veterans compensation and pensions. Special provisions governed the application of sequester in the Medicare program.
- 1986 - Age Discrimination in Employment bars mandatory retirement age (previously age 70).
- 1986 - McKinney Homeless Assistance Act (PL 100-77) liberalized Food Stamps for homeless families and provided far outreach to homeless.
- 1986 - PL 99-576, Veterans Benefits Improvement and Health Care Authorization Act of 1986.
- 11/86 - PL 99-660, State Comprehensive Mental Health Services Plan Act.
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1987 - Gramm-Rudman-Hollings (PL 99-177) amended (by P.L. 100-119) to revise deficit targets and modify sequester provisions previously found unconstitutional. As under PL 99-177 (1985), various benefit payments continued exempt from sequester. Railroad Tier II benefits were also exempted under 1986 OBRA.

1988-1989

Income Maintenance

Social Insurance

- 1985- - SS legislation consisted of adjustments in coverage and
- 1989 benefits and technical modifications.
- RR legislation in this period represented further efforts to deal with solvency issue.

Public Assistance

- 10/88 - PL 100-485, Family Support Act, provided major AFDC reforms; established Job Opportunities and Basic Skills Program (replacing WIN and related programs); required States to have unemployed-parent program by 10/90.

Health Care Delivery

Social Insurance

- 7/88 - PL 100-360, Medicare Catastrophic Coverage Act (MCCA) (to be effective 1/1/90); repealed in 1989.
- 12/89 - PL 101-234, repealed Medicare Catastrophic Coverage Act of 1988.
- 1989 - PL 101-239, OBRA revised physician payment system: Fee Schedule to phase in over 5 years beginning 1/1/92; provided for effective Medicare coverage (based on current premiums) for persons no longer getting SS disability benefits because of current work activity.

Public Assistance

- 7/88 - PL 100-360, non-repealed provisions of MCCH mandated coverage of women and infants, required States to "buy in," i.e., pay Medicare premiums and cost-sharing amounts for Qualified Medicare Beneficiaries (QMBs).
- 10/88 - PL 100-485 provided for Medicaid to continue during 1-year transitional period when AFDC ends. Also, States required to cover AFDC-UP families.

Private Sector

- 1988 - Retiree Benefit Bankruptcy Protection Act (PL 100-334) relates to treatment of retiree health benefits in bankruptcy cases.

Other Related Developments

- 1988 - A specially mandated Quadrennial Advisory Council, the Disability Advisory Council, submitted report which emphasized incentives and rehabilitation.
- PL 100-435, Hunger Prevention Act of 1988, raised maximum Food Stamp allotments and based allotments on Thrifty Food Plan.
 - PL 100-713 legislation further strengthened Indian Health Services.

1990-1991

Income Maintenance

Social Insurance

- 11/90 - PL 101-508, OBRA, included extension of SS coverage to State/local employees not under a retirement plan; provided for improvements in service to public; and added SS to the Federal programs that may recover debts by income tax refund offset. Also included Budget Enforcement provisions; excluded SS Trust Funds from unified budget; and provided special points of order and financing requirements for social security legislation.

Health Care Delivery

Public Assistance

- 1990 - OBRA (PL 101-508) provided many changes in Medicaid including required Cost Sharing Buy-in for Aged Medicare Beneficiaries up to 120 percent of poverty by 1975 and required coverage to age 19 of children born after 9/83 up to 100 percent of poverty.

Private Sector

- 1990 - Financial Accounting Standards Board issued FAS-106 requiring that for fiscal years beginning after 12/92, companies' annual reports must reflect total accrued liabilities for retiree health benefit plans.

Other Related Developments

- 7/90 - PL 101-336, Americans with Disabilities Act.
- 1990 - PL 101-508 included new Budget Enforcement Act partially suspending GRH provisions by providing new budget targets mini-sequesters by sector (defense, domestic or international) and providing pay-as-you-go requirements for entitlement legislation.

1991 - Statutory Commission on RR retirement reported to Congress regarding solutions to solvency problems.

Appendix B:

Recommendation Specifications

Improving Access to Care

A PROPOSAL TO ASSIST STATE DEPARTMENTS OF HEALTH TO ESTABLISH SCHOOL-BASED HEALTH CLINICS AND OFFER MAJOR-MEDICAL INSURANCE

Background

School-Based Clinics

School-based clinics in elementary schools have proven to be successful in several sites across the country. New York has an extensive and successful system, with about 90 elementary school-based clinics currently in operation. Enrollment is very high: 70 to 90 percent of students, with higher enrollment between 90 and 100 percent in one rural program. California has one operational in San Jose, and another is scheduled to open shortly.

Program activities include complete health histories, physical examinations, treatment for acute and episodic illness, counseling, immunizations, laboratory tests, nutrition and psychosocial services, and health education and counseling.

The use of primary and preventive health services in these programs has decreased inappropriate utilization of hospital emergency rooms and improved the health status of school-age children, leading to improved school attendance.

In many parts of the Nation, the number of pre-school immunizations has declined, resulting in a substantial rise in the incidence of childhood infectious diseases. In Florida, for example, the number of measles cases increased in 1990 by 290 percent. School-based clinics could be an instrument to combat this trend.

Major-Medical Insurance

Over 34 million Americans—16 percent of the nonelderly population—are now without any form of health insurance for all or part of each year. Of the 25 million uninsured adults in this group, 70 to 75 percent are working or seeking work and are employed at least part-time during the year; many others are dependents of those who work. But the majority of these Americans are in families with annual incomes below \$20,000 and therefore cannot afford health insurance unless it is partly or wholly subsidized by their employers.

Often, however, employers do not contribute to employee health plans. Small companies particularly, especially those of marginal profitability, are usually unwilling or unable to offer health insurance as an employee benefit. The Health Insurance Association of America estimates that health insurance is offered by only one in three firms with fewer than 10 employees. In the absence of health insurance coverage offered by their employers, low-income employees cannot readily pay major health care bills. This has a serious consequence for the health care of children in low-income families.

The school system is an ideal locus for assisting parents to meet the major health needs of children through the purchase of economical group policies of major medical insurance negotiated by the school system.

The Proposal

In General

The Council recommends the establishment of a federally assisted, nationwide system of health clinics located primarily in or adjacent to elementary schools of the State. State departments of health would operate the clinics—directly or through arrangements with health care providers—so as to offer wider and more regular access to primary health and dental care, including routine and preventive services, for all children of elementary school age and for pre-schoolers.¹

Federal-State Program

A "School-Based Health Services and Referral Act" would be proposed as a Federal grant program, administered by the Secretary of Health and Human Services, to reimburse States, in the manner described below, for their administrative expenditures in establishing and operating health clinics in public elementary schools of the State or in locations reasonably near public or private elementary schools within the State, and to share with the States the cost of providing clinic services to children from low-income families.

¹Approximately 12.2 million children younger than 17 have neither private nor public health insurance at some point during the year. National Health Policy Forum Intergovernmental Health Policy Project, "The States and the Uninsured: Slowly but Surely, Filling the Gaps," (Oct. 1990) p. 1. Presumably, between 9 and 10 million are pre-school and elementary school children and would be eligible for services under the program.

Services Provided

A clinic established under the Act would be required to make available to children of elementary school age and children of pre-school age the following services:

- preventive health care services, including immunizations, periodic well-child visits, and hearing and vision testing. This would include in-school mass immunizations and mass screenings;
- primary health care; and
- dental care.

Eligibility for Services

Any child of pre-school or elementary school age would be eligible to receive services at a clinic.

Provision of Services

Services may be provided by health care practitioners employed by the State Department of Health or engaged under contract. Insofar as is practicable, considering the location of the clinic and the patient population, the Department would endeavor to provide a physician who would be on duty at the clinic for all or part of each school day or alternate day, depending upon the number of children to be served.

Sources of Financing

Program services would be financed from multiple sources.

Medicaid eligibles. Medicaid (including the Early Prevention, Screening, Detection, and Treatment program) would pay for services to a child from a Medicaid-eligible family.

Children from low-income, non-Medicaid-eligible families. In the case of services to other children, from families with incomes up to 185 percent of the poverty line, payment would be on a sliding scale. But other sources of funding could include the Maternal and Child Health Block Grant and the State general medical assistance program.

Other children. For children from families not entitled to public or medical assistance, payment for services will be made by their families or their insurers on such basis as the State (in the case of a State-operated school) or school district may provide.

As in the school lunch program, a participant in the program would not be aware of the source of payment for other participants.²

²To avoid the stigma that may attach to a clinic providing services exclusively or largely to patients from families on public assistance, every effort should be made to promote these clinics as full service facilities—like physicians' offices—that exist to provide convenient health care services for all children. The State would be encouraged to accept credit card payments and personal checks in payment for services in order to foster the concept that these clinics are not simply facilities for the poor.

Payment for Contract Services at Prevailing Rates

Contract payment for health services would be at the prevailing rate in the community for services of the type that the clinic provides.

Location of Clinic

It is the objective of the program to encourage the establishment of a school-based clinic easily accessible to every child of elementary school age.

Public elementary schools. Insofar as is practicable, the Department would be required to establish a clinic on-site in existing public elementary school space.

Other locations. Where existing public elementary school space is inadequate and it is necessary to establish a clinic to make health care services readily accessible to students at that school, the Department may establish the clinic in commercial or other space.

Private schools. Clinics must be established to provide services to children attending private elementary schools.

Administration

Management of clinic. The Department of Health would operate each clinic directly or through arrangements with providers. The proposal would require the Department to make the fullest practicable use of local physicians and resources.

Matching rate. The Federal Government would reimburse the States for their entire cost to administer the clinics and would provide \$600 million annually to subsidize a sliding scale of fee payments for health care in the clinics of non-Medicaid eligibles from families with incomes up to

185 percent of the poverty line. The State would match the subsidy at a ratio of 25:75 (i.e., the State would pay 25 cents of each dollar). Funds would be allocated among the States on the basis of elementary school-age population in each State, as estimated in advance of each program year by the Bureau of the Census.

Payment of funds. The State would administer the funds through the Department.

Use of program funds. The Department could use program funds for the following activities:

Remodeling and renovation. Within specified limits, remodeling or renovating existing public school facilities or other space so as to create a site suitable for the provision of health care services.

Establishment and inspection. Department administrative expenses required to establish and regularly inspect the clinics.

Equipment. Purchase or rental of medical equipment deemed reasonably necessary to provide the health care services described in the "Services Provided" section above.

Furnishings. Necessary furnishings of the clinic, exclusive of medical equipment.

School-Based Major Medical Insurance

Availability. The program would also assist the States, through their school districts, to offer a voluntary supplemental low-cost insurance product, limited to paying the costs of major medical expenses, to all pre-school children and all elementary and secondary school children registered at schools of the State. The insurance would remain available until a

participant attained age 22, regardless of whether the participant remained in school.

Federal participation in subsidy. The Federal Government would reimburse the States, within an annual aggregate Federal program cost of \$500 million, for 75 percent of their expenses in providing subsidized insurance to students from families with family incomes up to 185 of poverty. A participating State would be subject to Federal limitations on the coverage that such insurance could offer.

Payment of State administrative expenses. A State that participated in the proposed school-based clinics program would also be reimbursed, under both programs, for its annual program administrative expenses.

Use of child support enforcement system. The child support enforcement provisions of the Social Security Act would be amended to clarify the authority of the courts to include, in a child support order, a requirement for the payment of the premiums to enable a child to enroll in the insurance program.

Administrative Expenses

In the case of a State that participated in both programs—school-based clinics and major-medical insurance—the Federal Government would pay the cost of State administrative expenses.

INCREASING ACCESS TO PRIMARY CARE

The Access of Underserved Population Groups to Health Care

Five population groups in our society are readily identified as sharing a high need for primary medical care coupled with relatively low access to it.

Migrant Workers

Because of their lifestyle, language, culture, and economic status, most migrant and seasonal farmworkers and their families have extremely limited access to primary health care. Some one-half million of them do receive health care at migrant health centers, but the number of physicians at these centers does not meet the existing need.

High-Risk, Low-Income, Pregnant Women and Infants

Infant mortality in the United States continues to be a problem. At 9.1 deaths per 1,000 births, the U.S. infant mortality rate is higher than that of 23 other industrialized countries.

The Health Resources and Services Administration (HRSA) of the Public Health Service, in its FY 1991 budget justification, announced the need for increasing services at community and migrant health centers to provide case-managed services to 75,000 high-risk pregnant women.³ This need still exists.

³Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations for 1991, Hearings before a Subcommittee of the Committee on Appropriations, House of Representatives, Part 3, p. 258.

The Uninsured Poor

Many people are without access to adequate health care because they lack insurance, live in communities without sufficient health resources, have health concerns not met by traditional medical care, or face other barriers to care. HRSA supports approximately 550 community health centers, which serve over 5 million of these people. Nevertheless, the number of physicians at these centers is generally recognized to be inadequate.

The Homeless

Physicians are needed to work in the approximately 92 "health care for the homeless" programs, which support a broad range of primary care, alcohol and substance abuse, and mental health services to 335,000 homeless individuals, including runaway adolescents, homeless pregnant women and children, and individuals with chronic substance abuse and mental health problems.

The Underserved, Low-Income, Rural Population

From 1975 through 1988, the number of active physicians engaged in primary care has increased dramatically.⁴

Despite this increase, some 360,000 people live in the 221 counties that have no physicians whatsoever, and substantially larger numbers live in counties containing only one or two physicians. Typically, the per capita income in these counties is low. For example, in almost 90 percent of counties having no physicians, per capita income is below the national average.

⁴Figures on the numbers and distribution of physicians among U.S. counties have been obtained from the Bureau of Health Professions of the Health Resources and Services Administration, United States Public Health Service.

Specialty	1975		1988		Percent Increase in Supply	Percent Increase in Rate
	Number of Active Physicians	Number per 100,000 Population	Number of Active Physicians	Number per 100,000 Population		
General Practice/ Family Practice/DO	64,655	30.3	87,749	36.1	35.7	19.1
Internal Medicine	48,012	22.5	68,584	28.2	42.8	25.3
Pediatrics	20,002	9.4	36,399	15.0	82.0	59.6
Obstetrics and Gynecology	20,307	9.5	30,986	12.7	52.6	33.7

Between 1975 and 1988, the last year for which firm data are available, there was no increase in the number of counties (2,928) containing physicians (or DOs) in general or family practice. In short, counties with no physicians seem destined, other things being equal, to remain counties with no physicians.

In reporting the FY 1991 Labor-HHS-Education and Related Agencies Appropriations Act, the House Appropriations Committee said:

The Committee is concerned that a severe shortage of physicians and other health care providers exists in medically underserved rural and urban areas. More than 12 million Americans live in areas that lack primary health care providers. H. Rept. 101-591, p. 28.

The problem is aggravated by the fact that many of the counties that have fewer than three physicians are not especially hospitable to the establishment of a new medical practice. The following table illustrates this, suggesting that in many medically underserved areas, there is little prospect of establishing a self-supporting medical practice.

Percentage of Counties, Grouped by Number of Physicians, Having No Businesses of Selected Types				
Type of Business	County Group (%)			
	No Physician	1 Physician	2 Physicians	More Than 3 Physicians
Food Store	10	7	0	0
Eating Establishment	14	12	0	0
Gasoline Station	16	12	5	0
Bank	20	2	1	0
Hardware Store	41	13	6	1
Lawyer	49	22	11	2
Drugstore	58	18	9	1
Variety Store	53	38	26	2

The National Health Service Corps

The National Health Service Corps (NHSC), which encourages the diffusion of primary care physicians as well as dentists and other health care professionals into medically underserved areas (known as "Health Professional Shortage Areas") has not effectively fulfilled this mission in recent years. In 1982, NHSC suspended the award of new scholarships for medical students who agreed to practice in these areas. In the years intervening prior to FY 1991, the administration and the Department of Health and Human Services attempted to phase out NHSC activities. As a result, in order to carry out its statutory mandate during these years, the Corps was forced to spread decreasing resources over a multitude of health care specialties. Nevertheless, in 1990 the Corps had in place 1,751 health professionals to provide services to areas that cannot otherwise recruit or retain health practitioners.

Both Congress and the Department have now moved to reverse the NHSC phaseout. The loan and scholarship programs, which received only

\$11.4 million for FY 1990, were increased to \$48.8 million for FY 1991 and \$58.8 million for FY 1992; funds for field placement were raised from \$39.3 million in FY 1990 to \$42.3 million for FY 1991 and 1992.

Advisory Council Recommendation

The Council's proposal to assist State departments of health to establish school-based health clinics will result in making primary health care services available to between 9 and 10 million elementary school children who are in families that are without health insurance for all or some part of the year. The Council recommends that funds be provided to serve a further 2.1 million uninsured persons.

Community and Migrant Health Centers

Specifically, \$250 million in new Federal funding should be made available to establish 250 new community and migrant health centers to be located in underserved areas or in areas with high concentrations of underserved target populations. An additional \$290 million should then be provided in annual operating funds.

R.E.A.C.H. Demonstration

The Secretary of Health and Human Services would be authorized to establish, as a demonstration project, 20 centers to provide rural emergency access for community health (R.E.A.C.H. centers). These could be free-standing centers, could be consolidated with existing community or migrant health centers currently serving these areas, or could be incorporated in the design of new community or migrant health centers.

National Health Service Corps

The Council strongly recommends legislation be enacted to permit the Secretary of Health and Human Services and the Assistant Secretary for Health to revise the priorities of the National Health Service Corps so as to focus more attention on demonstrated unmet need.

Specifically, NHSC should be authorized to increase the access of target populations to primary medical care, that is, the urban and inner-city poor, especially infants and children; high-risk pregnant women; migrant workers and their families; drug and alcohol abusers; and the homeless.

The NHSC should be authorized to encourage primary care physicians to serve in community and migrant health centers or in related health programs, or in underserved rural areas and offer them incentives for efficient private practice in the areas in which they locate. The Council recommends an increase of \$100 million for the budget of the NHSC to fund these activities.

The Secretary should be authorized to direct the Corps to take two measures that the Council believes will be especially productive in accomplishing these objectives:

- In awarding National Health Service Corps scholarships, the Corps should, more actively than at present, seek to recruit individuals from the medically underserved areas in which they will be asked to serve upon graduation.
- To encourage NHSC graduates to remain in medically underserved areas after they have discharged their service obligation to the Corps, the Corps should develop the means of encouraging them to join large medical groups, hospitals, and health care systems operating in, or within a reasonable distance from, those areas.

To facilitate implementation, the Advisory Council also recommends that the Corps be required to prepare a written plan describing the actions that it will take so as to refocus its activities as described. The plan should contain measures by which its success can be measured objectively and, after approval by the Secretary, should be published in the *Federal Register*.

A PROPOSAL TO REDUCE INFANT MORTALITY

The Problem of Infant Mortality

Each year in the United States nearly 40,000 infants die before their first birthday.⁵ The United States infant mortality rate is 9.1 deaths per 1,000 and ranks 24th among the rates of industrialized nations. The infant mortality rate among blacks remains more than twice as high as that for whites: 17.6 deaths per 1,000 live births compared with 8.6 deaths.⁶

As the President's FY 1992 budget observed:

Infant mortality is a critical problem, particularly in many large urban areas in the United States. Early and regular prenatal care reduces infant mortality, prematurity, and low birth weight.

The major determinant of infant mortality is low birth weight. The less a baby weighs at birth, the greater the risk of infant death. For example, a baby who weighs under 5 1/2 pounds is 40 times more likely to die during the first month of life than an infant at or over that weight. Nationally, about

⁵The lowest 10 countries were Japan (5.2), Finland (5.8), Sweden (5.9), Switzerland (6.8), Taiwan (6.9), the Netherlands (7.7), Canada (7.9), France (8.0), Denmark (8.4), Ireland (8.7), Spain (9.0), a united Germany (8.3 to 9.2), the United Kingdom (9.5), Belgium (9.7), and Australia (9.8).

⁶ The infant death rate in the United States fell to 9.7 in 1989. The drop to 9.1 in 1990 was a decline of 6 percent from the 1989 figure, compared with an annual decline within the United States during the last decade of 2.5 percent. See *The Washington Post*, Sunday, April 7, 1991, page A12, reporting information that the Department of Health and Human Services was preparing to announce at a press conference.

7 percent of all live births are low-birth-weight babies, whereas 60 percent of infant deaths are low-birth-weight infants.⁷

Nor do the mortality figures tell the whole story. Another 100,000 infants annually suffer disabilities, such as blindness, deafness, and mental defects, associated with low birth weight. Low-birth-weight infants are three times more likely to have neurodevelopmental handicaps, such as cerebral palsy and seizure disorders, and are more susceptible to respiratory conditions.⁸ Low-birth-weight infants often require lengthy hospitalization, and almost one-fifth of those hospitalized are re-hospitalized during the first year.

To fight infant mortality and morbidity, the National Commission to Prevent Infant Mortality recommended that the health and well-being of mothers and infants be made a national priority, with universal access provided to early maternity and pediatric care for all mothers and infants.⁹ It is pointed out that:

Prenatal care costs as little as \$500 per pregnant woman. Neonatal intensive care costs for high-risk babies born to mothers who do not get prenatal care can reach as high as \$500,000.

The Commission observes:

The importance of early prenatal and pediatric care in reducing infant mortality and preventing disability is well substantiated. Comprehensive

⁷"Data Supplement: Strengthening National Efforts to Improve Infant Health," Office of the Assistant Secretary of Health, Department of Health and Human Services (Nov. 1990).

⁸The Secretary of Health and Human Services, Dr. Louis Sullivan, in an interview on the McNeill/Lehrer News Hour of April 8, 1991, attributed the most recent reduction in infant mortality largely to improved therapy for respiratory disease syndrome.

⁹"Death Before Life: The Tragedy of Infant Mortality," The National Commission to Prevent Infant Mortality (Aug. 1988), p. 12. To the same effect: "Troubling Trends: The Health of America's Next Generation," The National Commission to Prevent Infant Mortality (Feb. 90), p. 39.

prenatal and pediatric care, received early and often, could potentially reduce this country's infant mortality rate by at least half.¹⁰

Despite this, a 1987 study by the Alan Guttmacher Institute concluded that one of every three pregnant women gets insufficient prenatal care.¹¹ Each day in America, 3,548 infants are born to mothers who received less than adequate prenatal care; 719 infants are born with low birth weight; and 105 infants die. The National Center for Health Statistics reported that 70,327 pregnant women in the United States in 1986 received no prenatal care whatever, a larger percentage than in 1980.¹²

The Current Federal Effort

The Federal Government currently devotes substantial resources to reducing infant mortality.

Medicaid

In FY 1990 Medicaid programs assisted about 2.2 million pregnant women and children. Federal and State Medicaid expenditures for pregnant women and infants were about \$5.4 billion, including a \$3.1 billion Federal share. Effective April 1, 1990, States were required to extend eligibility to pregnant women and children up to age 6 in families with incomes at or below 133 percent of the Federal poverty level. Nineteen States have also exercised the option to extend eligibility for women and infants in families with incomes up to 185 percent of poverty.¹³ Under the Omnibus Budget

¹⁰"Home Visiting: Opening Doors for America's Pregnant Women and Children," The National Commission to Prevent Infant Mortality (July 1989), p. 6.

¹¹Alan Guttmacher Institute, "Blessed Events and the Bottom Line: Financing Maternity Care in the United States" (1987).

¹²National Center for Health Statistics, "Advance Report of Final Monthly Statistics, 1986" (1988).

¹³Op. cit. note 11, p. 13.

Reconciliation Act of 1990, States must continue eligibility for pregnant women until the end of the second full month after pregnancy, and an infant born to a Medicaid-eligible woman remains eligible (so long as the mother remains eligible) until its first birthday.¹⁴

Community and Migrant Health Centers

As part of its support for 525 community and migrant health centers across the nation, the Health Resources and Services Administration of the Public Health Service expends an estimated \$195 million in support of services to between 180,000 and 210,000 low-income pregnant women and to infants. Other Federal and State funds include \$31.6 million for enhanced prenatal care to especially vulnerable populations (i.e., the Comprehensive Perinatal Care Program, which affects services for about 130,000 women, including about one-third of all pregnant women in the United States under the age of 15).¹⁵

Maternal and Child Health (MCH) Block Grant

The MCH program awarded some \$587 million to States in FY 1991 for preventive and primary care services to mothers and children, health screening, immunizations, and rehabilitation services for children with special needs. More than one-half million women annually receive prenatal care partly subsidized by these funds.

¹⁴Section 4603 of the Omnibus Budget Reconciliation Act of 1990, which amends §1902(e) of the Social Security Act.

¹⁵Op. cit., n. 11, pp. 14-15.

The Special Supplemental Food Program for Women, Infants, and Children (WIC)

The WIC program awards formula grants to States for no-cost supplemental foods and nutrition education for pregnant and post partum women, infants, and children identified as at risk of malnutrition. In FY 1991, the program expended about \$2.35 billion, assisting about 4 1/2 million people each month.

Numerous smaller programs supplement these four major programs. They include:

- Indian Health Service care provided to American Indians and Alaska Natives living on or near a reservation.
- Assistance to the States by the Centers for Disease Control in surveillance and epidemiology related to infant health.
- Research conducted by the National Institute of Child Health and Human Development as well as other Institutes of the National Institutes of Health.
- Services supported by the Alcohol, Drug Abuse, and Mental Health Administration for women who abuse drugs or alcohol.
- The Commodity Supplemental Food Program, which provides food donations, commodities, and grants to States for administration of programs to improve the health and nutritional status of low-income pregnant, post partum, and breast-feeding women, infants, and children.

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- The Food Stamp Program.
 - Selected activities of the ACTION agency and VISTA.

Barriers to Reducing Infant Mortality and Morbidity

Criteria for Effectiveness

Both the number and cost of Federal activities intended, directly or indirectly, to reduce infant mortality and improve or sustain the health of pregnant women and of mothers and their infant children, are substantial. The President's FY 1992 budget asks for more than \$8 billion to support programs to reduce infant mortality, an increase of 9.2 percent (\$676 million) over the preceding fiscal year.¹⁶ Nevertheless, in order for any of these programs to be effective, it must fulfill three conditions:

- It must ensure that a pregnant woman or the mother of an infant learns of the program's existence and value.
- It must then offer her reasonable access to its services.
- Having provided that access, it must deliver what it promises.

Failure of Programs to Meet Criteria

Many of the cited programs fail, in some degree, on one or more of these counts. For example, a recent study by the Urban Institute estimated that only about 60 percent of pregnant women and infants eligible for Medicaid were actually enrolled in the program: 655,000 pregnant women and 717,000

¹⁶Budget of the United States Government, Fiscal Year 1992, Part Two, p. 27.

infants.¹⁷ Young, first-time mothers are often unaware of available programs. And social and cultural factors may leave women in ignorance of the value of prenatal and well-baby care.

Improved informational outreach will not itself solve the problem of inadequate health care for pregnant women and infants. As the President of the American Public Health Association observed in 1987:

We have been plagued too often by entitlement without availability, as illustrated by providers who refuse Medicaid patients, and by availability without entitlement, as illustrated by hospitals that turn away the uninsured.¹⁸

The Problem of Access

Two of the more significant barriers to access are the following:

- Lack of transportation and child care to enable women to make and keep prenatal care appointments.
- Formidable paperwork requirements and the qualifying process for public programs.¹⁹

The Problem of Availability

More significant than these barriers to access is the unavailability of the care to which public programs purport to entitle these women. Although there are

¹⁷Cited in the Data Supplement, op. cit. n. 11, p. 22.

¹⁸Ruth Roemer, "The Right to Health Care—Gains and Gaps," *American Journal of Public Health*, March 1988, Vol. 78., No. 3, p. 242.

¹⁹A 1988 study, cited in the Data Supplement at p. 26, "found that Medicaid applications average 14 pages in length and often require extensive documentation, such as birth certificates, pay stubs, and bank account numbers."

many publicly funded health centers, they are generally understaffed. At most health clinics and centers, women must wait between 2 and 4 weeks for a first appointment; at one-fifth of them, the wait is longer than 4 weeks. Also, many of these clinics and centers are unable to offer a full range of pregnancy-related care because of a lack of physicians.

The lack of prenatal and obstetrical care providers is a serious problem in many parts of the country, especially in rural and inner-city areas. In part, the shortage is caused by the high cost of malpractice insurance and the risk of liability which has caused many private physicians to abandon obstetrics In many States the problem is compounded by low Medicaid reimbursement rates.²⁰

The Proposal

An Approach to Reducing Infant Mortality

The previous sections of this paper illustrate that, although many programs seek to reduce infant mortality, its incidence is bound up in societal problems not readily solved. The challenge to government is not to devise further programs, but to use more effectively those that exist. Accordingly, the proposal that follows seeks to sharpen institutional weapons already deployed.

²⁰Op. cit. n. 11, p. 23.

A Proposal in Outline

As part of a renewed attack on infant mortality, legislation should be proposed to:

- Integrate the WIC program with the MCH Block Grant program. This would include a reassessment of all current MCH program efforts to reorient them to meet today's MCH needs. The restructured programs would be administered by the Department of Health and Human Services rather than the Department of Agriculture but would continue to support activities now conducted under either program;
- Require States to furnish locations at which an eligible woman could establish her entitlement, or that of her infant, both to MCH/WIC benefits and to Medicaid;
- Introduce a simplified application form for MCH/WIC/Medicaid eligibility and offer the applicant presumptive eligibility for all programs;
- Use publicly financed providers for "one-stop shopping," i.e., a single location both for determining eligibility for all programs pertinent to infant mortality and for providing health services;²¹

²¹In "Collaborative Strategies to Improve State & Local Public Health Systems," National Academy for State Health Policy (Aug. 1990), a report prepared under contract with the Health Resources and Services Administration of the United States Public Health Service, the authors, in discussing the establishment of integrated health care delivery systems involving publicly financed providers, such as the Community and Migrant Health Centers, local health departments, and public hospitals, recommend as follows:

Community Health Centers can serve as the linchpin in "one-stop shopping" projects that streamline procedures essential for expanding service access (e.g., on-site Medicaid eligibility determinations) and coordinating resources to assure access. In South Carolina, for example, Beaufort-Jasper Comprehensive Health Services staffs the local WIC program and, under contractual agreements with state and local health departments, serves as the principal provider of perinatal, MCH, WIC, EPSDT, and immunization services for its locality. On a wider geographic scale, the Primary Health Care Consortium of Dade

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- Support outreach activities to publicize the existence of the program to potential eligibles and make program funds available for transportation and child care to enable mothers to meet health care appointments;
 - Establish a demonstration program of incentives to encourage women to obtain prenatal and well-baby care; and
 - Support an extensive demonstration program of home visits to assess a family's health and social needs, encourage its use of prenatal care and well-child checkups, and assist it in obtaining health, social, and related services available in the community.²²

Additional Program Features

Use of modified block grant mechanism. The integrated MCH/WIC program, like the existing MCH program, would be structured as a block grant to the States, controllable by annual appropriations action. It would, nevertheless, require participating States to meet program objectives described in the section "A Proposal in Outline."

Availability of program benefits. Food and services under the program would be available to all pregnant women and infants, regardless of income, although the State would be allowed to charge for food or services provided

County (Miami, Florida) is an organized network involving all providers of publicly financed care. [At p. 15.]

²²In "Home Visiting: Opening Doors for America's Pregnant Women and Children," op. cit. n. 14, the National Commission to Prevent Infant Mortality explains:

Consistently, the main function of home visiting is to assess a family's health and social needs and to provide the link between a family's front door and the assortment of health, social, and "other" services that exist in a community to meet their needs. Home visitors have traditionally been seen by families as the "ombudsman"—the bridge between the system and the family's front door. [At p. 4]

The Commission also maintains that home-visiting efforts can increase use of prenatal care, discourage unhealthy behaviors, increase the use of well-child checkups, improve parenting skills, and reduce the number of emergency room visits for routine health care problems. [At p. 7]

to individuals other than low-income mothers or children. In such case, the State would be required to scale those charges in proportion to the income, resources, and family size of the (non-low-income) individual assisted.

Supplemental grants for high-risk populations. The program would reserve a proportion of total grant funds for grants, by the Secretary, to States, counties, cities, and other political subdivisions of the States for innovative approaches to enhancing the program for high-risk populations. The Secretary would be required to develop a system of priorities for awarding such grants, with preference to be given to assisting children with special health care needs, chronically underserved populations, and other populations within which infant mortality is significantly higher than the national average.

National Health Service corps priority. The Public Health Service Act would be amended to establish a priority for the assignment of National Health Service Corps primary care physicians to areas (whether or not "underserved") that are shown to suffer annual rates of infant mortality exceeding, by 50 percent or more, the average annual rate of infant mortality among the white female population of the United States.

Maternal and Child Health Information Program. The program would generate maternal and child health information at two levels:

- **Written information.** Within the Federal administering agency, there would be created an Office of Maternal and Child Health Information. The Office would be responsible for developing and disseminating written prenatal and child-care information to all women of child-bearing age within the United States.
- **Classes.** As a condition of Federal financial participation, a State would be required to develop classes in prenatal care, child-care, and child-nurture and make them accessible to pregnant women, mothers,

fathers, and (within the limit of program resources) all other women of child-bearing age. The Office of Maternal and Child Health Information would be authorized to cooperate with the States in preparing written course materials.

Prenatal care incentives. In order to encourage women, particularly low-income women, to avail themselves of services intended to reduce infant mortality and improve the nutrition and health of mothers and children, the program would undertake a demonstration of the effect of offering incentives, in the form of additional subsidization of prenatal, obstetrical, and well-baby care charges.

A PROPOSAL TO PROMOTE EMPLOYER-BASED HEALTH INSURANCE

This is a four-part proposal to encourage the provision of employer-based health insurance.

A Model State Law to Regulate Health Care Benefit Programs Offered to Small Employers

Development by Secretary

The Secretary of Health and Human Services would develop and promulgate a model law, for adoption by the States, to regulate health care benefit programs offered to small employers.

Applicability

The law would apply to a group health benefit plan covering employees of small employers, i.e., employers of from 2 to 50 employees.²³

²³References to "insurance carrier" include any other provider; references to "arrangements" include multiple employer welfare arrangements; and references to "policy" include any health care arrangement with a carrier or other provider.

Requirements of Plans

These plans would be required to meet the following conditions:

- **Pre-existing conditions.**
 - No exclusion would be permitted for a pre-existing condition that had not manifested itself during the 6 months immediately preceding the date of coverage.
 - No exclusion of a pre-existing condition (that had not so manifested itself) could run beyond 12 months following the date of coverage.
 - No exclusion of a pre-existing condition would be permitted because the employer changes carriers or the employee changes employers (if the employee had met the above-described time periods under the previous policy and coverage is continuous).
- **Renewability.** A policy would be renewable at the option of the policy-holder if the policy-holder had complied with all coverage requirements (payment of premiums, absence of fraud or misrepresentation, etc.).
- **Exclusion of eligible employee or dependent.** A carrier would be permitted to use medical underwriting only to determine the level of risk within a group, not for the purpose of excluding an individual from group coverage. An arrangement could not exclude any member of the employment group (or the members' dependents).
- **Guaranteed availability.** A policy could not be denied to any small-employer group, regardless of risk.

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- **Waiting period.** A plan would be required to make coverage available to all eligible employees in an employment group without a service waiting period (i.e., a period during which a new employee is required to work for the employer before enrolling in the plan).
 - **Premiums for similar groups.** A carrier would be required to limit variations in premiums for similar groups (groups in the same geographical location, with similar demographic composition and plan design) to no more than 35 percent from the carrier's midpoint rate.
 - **Premiums for different industries.** A carrier would be required to limit variations in rates between industries to no more than 15 percent.
 - **Annual premium increases.** A carrier would be required to limit annual premium increases to no more than 15 percent above the year-over-year increase in the lowest new business rate for managed and nonmanaged care plans (treated separately).

Federal Standards

Federal legislation would be enacted to provide that if a State does not adopt the model act within 3 years after the Secretary promulgates it, the act's standards for insurance policies shall go into effect as Federal standards for all policies offered to small employers within the State.

Assessment of Employers

All insurers within the State would agree on risk categories that would place employees of all or many small employers within the State into one or more statewide risk groups. The State could enact legislation to assess all employers within the State for contributions or take other steps to raise revenue to fund the risk pool.

State Reinsurance

If insurers within a State do not establish a pooling arrangement and the State determines that the absence of such an arrangement is a substantial impediment to the availability within the State of low-cost policies of health insurance for employees of small employers, the State would be expected to establish a reinsurance pool.²⁴ All carriers and other organizations issuing health benefit plans would be members of the program, including Blue Cross and Blue Shield. Nevertheless, Blue Cross and Blue Shield would be permitted to manage their own reinsurance risk if they (jointly) chose to do so.

Disallowance of State-Mandated Benefits for Small-Employer Core Health Benefit Plans

Background

It has been estimated that State-mandated benefits account for between 15 and 25 percent of the family premium for employer-provided group health plans. Mandated benefit laws fall into four categories, described by the Congressional Research Service²⁵ as roughly equivalent to the questions "who, what, when, and where." The categories are:

- Dependents: the kind of persons to be covered under a contract.
- Benefits: the kind of services to be covered under a contract.

²⁴Under the McCarran-Ferguson Act, Federal antitrust laws apply to the insurance business, except to the extent that the business is regulated by State law. For various reasons, most State insurance laws now exclude reinsurance transactions. In order to implement the pooling arrangements proposed in the text, States would be expected to amend their laws to authorize them.

²⁵Congressional Research Service, Library of Congress, *Health Insurance and the Uninsured: Background Data and Analysis* (May 1988), p. 73.

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- **Continuation/Conversion:** the length of time that coverage must be in effect.
 - **Provider:** the numbers and types of providers eligible to perform and be reimbursed for covered services.

The State mandate is intended to define what the State considers necessary care: what, at a minimum, an insurance plan must contain. Nevertheless, these mandates vary widely from State to State, from a few mandated benefits to several hundred, and often include benefits—hair transplants, in vitro fertilization, and the Chinese medicine option are examples—that uninsured or insured persons might willingly forego to obtain lower premiums.

The average State-mandated benefit provision, e.g., outpatient psychiatric benefits, adds about 2 to 5 percent to the costs of a typical medium or large employer's plan. This additional cost may be a factor in preventing businesses, particularly small businesses, from purchasing health care insurance for their employees.

The Proposal in General

Federal legislation would be proposed to relieve health care insurers, and other organizations that offer core benefit health plans to employers, from State requirements that health insurance policies contain specified benefits and cover services by designated categories of health care providers.

Plans Covered

The proposal would cover any contract that offers, to an employer of between 2 and 50 employees, hospital or medical benefits, or both, whether offered by an insurance carrier, a hospital, a medical service corporation, a

health maintenance organization, a multiple employer welfare arrangement, or provider.

Override of State Law

With respect to the employer plans covered, the legislation would override two types of State requirements: those that compel an insurer to include specific benefits in its health policy (except requirements for major medical benefits) and those that compel an insurer to cover services provided by designated categories of health care providers.

Exemption from Override

A State would be exempt from the override described in the preceding paragraph if it has both adopted the model law described under part I and established its own standards, approved by the Secretary of Health and Human Services, for the exemption of core health benefit insurance packages from State-mandated benefit laws.

Definition of Core Benefits

The Secretary of Health and Human Services, through a formal rulemaking process to define the term "core health benefits," would establish standards for health plans that would qualify for the exemption from State-mandated benefit laws and the State exemption from the override described the previous two paragraphs.

Preemption of State Laws Limiting the Use of Managed Care in Health Benefit Plans

State Impediments to Managed Care

What is usually known as "managed care" incorporates mechanisms into health coverage plans to coordinate all of the care required by a patient for a particular condition and provides incentives for a patient to obtain care from the more efficient providers. Managed care arrangements may include utilization review, quality assurance, physician practice pattern monitoring, case management, wider use of primary care physicians, assurance of the use of efficient providers, and the use of economic incentives to induce providers to hold down the costs of care without compromising its quality.

Many States have erected barriers to one or more of these devices, for example:

- Laws requiring managed care networks to open their panel of preferred providers generally or at certain times for entry by a provider willing to meet the panel's terms and conditions.
- Requirements that managed health care plans offer services of chiropractors.
- Restrictions on the financial incentives that may be used by managed care plans (e.g., prohibiting differential copayments and deductibles that encourage utilization of managed care).
- Prohibitions on discounts and alternatives to the "reasonable, usual, and customary" charges method of reimbursement.
- Restrictions on the use of utilization review.

Although some of these restrictions are commonly defended as a means of preventing a deterioration of the quality of health care provided under employer-based plans, there seems to be no evidence to support the contention that in their absence (as, for example, in self-insured employer plans exempt from these restrictions under the Employee Retirement Income Security Act) there has been any such deterioration.

The Proposal in General

Federal legislation would be proposed to relieve health care insurers, and other organizations that offer health benefit plans, from State limitations on the use of managed care. In order to safeguard the patient from the erection of unreasonable barriers to adequate medical treatment that this supersedure might invite, the Secretary of Health and Human Services, through a formal rulemaking process to redefine the term "managed care," would establish standards for alternative limitations that a State could impose.

Plans Covered

The legislation would cover any contract that offers hospital or medical benefits, or both, whether offered by an insurance carrier, a hospital, a medical service corporation, a health maintenance organization, a multiple employer welfare arrangement, or provider.

Override of State Law

With respect to the employer plans covered, the following laws of a State would cease to apply:

- laws that inhibit carriers from contracting with providers;
- laws that restrict carriers' ability to negotiate with providers regarding reimbursement; and

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- laws that restrict the inclusion of financial incentives to patients in managed care plans.

The override would not otherwise impair a State's power to regulate insurance carriers.

Managed Care Defined

As explained earlier, the Secretary of Health and Human Services, through a formal rulemaking process to redefine the term "managed care," would establish standards for limitations on managed care that a State would be permitted to impose.

Improving the Portability of Private Health Insurance

Background

An employee who changes jobs will often lose coverage under the health plan sponsored by the employee's former employer. This loss of coverage becomes a significant concern for the employee with a chronic health problem or with a dependent child in need of continuing medical care if the new employer's health insurer excludes coverage of new employees based on their pre-existing health conditions, claims experience, receipt of health care, medical history, or lack of evidence of insurability.

The Proposal in General

The Council would recommend legislation intended to induce health insurers to extend employer-based health plan coverage to new employees with a history of recent prior health coverage without imposing restrictions relating

to pre-existing health conditions, claims experience, receipt of health care, medical history, or lack of evidence of insurability.

Elements of the Proposal

Imposition of tax. The Internal Revenue Code would be amended to impose a substantial tax on the carrier of a group health plan that does not meet the portability requirements described below.²⁶

Portability requirements.

Individual insured within the preceding 3 months. The group health plan would be barred from excluding a new employee from covered services on the basis of a pre-existing health condition if the employee had been covered under the health plan of a previous employer within the 3 months preceding the new employment.

Other Individuals. The group health plan would be prohibited from imposing a waiting period of more than 6 months for an individual who has been diagnosed or treated for a health condition within 3 months of the time that, as a new employee, he would otherwise have been covered under the employer's health plan.

²⁶The proposed "Better Access to Affordable Health Care Act of 1991," S.1872, a bipartisan proposal introduced in the Senate on October 24, 1991, by Senator Lloyd Bentsen, would impose a tax of \$100 a day for this purpose.

HEALTH INSURANCE FOR THE SELF-EMPLOYED

The Problem

Under current tax law, a corporate employer may fully deduct as a business expense the costs of providing health insurance coverage to its employees. Although that cost represents an economic gain for an employee, it is excluded from the calculation of the employee's gross income for income tax purposes. The employee may deduct his contribution to the cost of the coverage to the extent it exceeds 7 1/2 percent of adjusted gross income.

In contrast, under a provision of the 1986 Tax Reform Act, an individual who is self-employed is entitled to deduct only 25 percent of health insurance costs as a business expense. The balance is deductible, as in the case of an employee, to the extent it exceeds 7 1/2 percent of the taxpayer's adjusted gross income.

As a result of this disparity, one who is self-employed pays a larger after-tax amount for health insurance than the combined amount paid by a corporate employer and its employee for the same benefits. Moreover, the cost of health insurance for a self-employed individual will normally be far in excess of the total cost of a policy available to a large corporate employer.

The current provision is scheduled to expire for taxable years beginning after June 30, 1992.

The Proposal

The Council believes that the self-employed should receive more equitable treatment. It recommends that the Treasury Department review the deductibility of health insurance premiums paid by the self-employed with a view to proposing an amendment of the tax laws that would place the self-employed on the same footing as employees in regard to the tax treatment of premiums for health insurance coverage.

Appendix B:

Recommendation Specifications

Reducing Health Care Costs and
Increasing GNP Growth

TASK FORCE ON INVESTMENT IN HUMAN RESOURCES

The Problem

Enhancing the productivity of American workers is essential to keeping America competitive in the world economy and providing the best support for the American people as we move toward the 21st century. A healthy work force is a key component of enhancing productivity.

Improvement of health status is complicated and involves many aspects beyond the financing of health care services. Improvements in education, housing, nutrition, and alcohol and drug abuse prevention and treatment must also be made if we are to ensure that Americans achieve their productivity potential.

The problems addressed by programs in health, education, housing, nutrition, and alcohol and drug abuse treatment programs are separate and dispersed across many different Federal agencies. A mechanism is needed to facilitate communication and coordination of Federal efforts in the preparation of a comprehensive strategy to maximize the ability of Americans to be competitive and productive workers.

The Proposal

Establishment of Interagency Task Force

The Council recommends that the President establish an Interagency Task Force on Investment in Human Resources.

Composition

The Task Force would comprise:

- the Secretary of Health and Human Services, who would serve as Chair,
- the Secretary of Agriculture,
- the Secretary of Education,
- the Secretary of Housing and Urban Development,
- the Secretary of Labor,
- the Secretary of Commerce,
- Administrator, Environmental Protection Agency, and
- Chairman, United States Commission on Civil Rights.

The Council would be empowered to invite the participation of other Federal agencies not listed as it may require for particular issues.

Mission

The Task Force would be charged with developing a comprehensive inter-agency strategy to improve investment in American human resources and society and thereby improve productivity and competitiveness. In each of the areas that it considers, the Task Force would:

- develop a statement of national goals to be pursued,
- assess the status of that area in relation to those goals,
- identify the major impediments to achieving those goals, and
- propose alternative means of removing those impediments.

Areas of Concern

The Task Force would appraise the effects of the current state of education, housing, nutrition, and alcohol and drug abuse on the health status of the American workforce and the consequent effects of current health status on national productivity and competitiveness.

5-Year Strategy

The Task Force would develop a comprehensive 5-year strategy detailing how Federal agencies can address the problems identified. The strategy would include:

- the development of a plan that includes a process so that Federal agencies can work together to minimize duplication in programs addressing these problems and maximize the use of existing resources;
- a list of actions that can be taken by Federal agencies, without changes in law, to implement the strategy;
- a timetable for implementation of the strategy and a plan for evaluating and ensuring that the timetable is met; and
- recommendations for changes in law that would be necessary to further the strategy.

Report

The Task Force would prepare semiannual reports to the President containing updates on the implementation of the strategy and recommendations for legislation.

Staffing

Staff for the Task Force would be drawn from personnel of the agencies represented.

A PROPOSAL TO DEVELOP INFORMATION ON MEDICAL TREATMENT OUTCOMES

The Problem²⁷

The cost of medical care is vastly increased by what is termed the "welfare uncertainty principle."²⁸ The principle holds that it is not possible to correlate the health of a population within a given hospital market area with the volume of health care services utilized within the area. In other words, population welfare may well be greater in a hospital market with less utilization than in one with more utilization.

The fundamental reason for this lack of correlation is that medical treatment theory is undervalued. The absence of exact information on the probable outcomes of various treatment modalities opens the way to supplier-induced demand. Dr. John E. Wennberg has put the matter this way:

There is no "invisible hand" arising from the doctor/patient relationship that regulates the supply of resources. Rather, undervalued medical theory and the supply of resources are in equilibrium: The treatment theories governing the use of hospital beds are sufficiently flexible to allow the use of hospital beds, no matter what the per capita level of supply; the theories that establish the legitimacy of surgical treatment justify surgical workloads, no matter what the number of surgeons; and undervalued medical treatment theory is

²⁷ The conceptual foundation of this recommendation has been supplied by a paper, "Iowa Leadership Consortium on Health Care Strategies for Reform," prepared by John E. Wennberg, M.D., M.P.H. Dr. Wennberg's recommendations go far beyond those contained in the instant proposal.

²⁸ Wennberg, *op. cit.* n.1, p.6.

sufficiently rich to deploy internists and family practitioners virtually without regard to how many there may be per capita.²⁹

But, designed on the misapprehension that capacity will be limited by medical efficacy and patient demand, the major Federal programs of health care financing, as well as many private insurance programs, make resources freely available at the point of utilization. Confronted with the reality of supplier-induced demand fueled by alternative, underevaluated, treatment modalities, the programs are therefore generating a crisis in the cost, access, and quality of medical care.

The Proposal

The Department of Health and Human Services, through the Agency for Health Care Policy and Research (AHCPR), is supporting research on the appropriateness and effectiveness of alternative strategies for the prevention, diagnosis, treatment, and management of a variety of acute and chronic conditions and along with other entities is developing medical practice guidelines for use by health care providers. Practice parameters, the development of which by the medical profession is strongly advocated by the American Medical Association, will encourage and enhance the delivery of the most appropriate care to each patient. They would supplement the physician's judgment in reducing unnecessary and inappropriate variation in the use of health care services and procedures.

The Advisory Council recommends that AHCPR develop a system that would produce comprehensive reports on the performance of local and regional health care markets. The reports could be used to repair flaws in three critical policy areas: information, finance, and manpower. As

²⁹ Wennberg, *op. cit.* n.1, p.3.

proposed by Dr. Wennberg, reports would include the following information:³⁰

- the location of local and regional market areas;
- the per capita allocation of hospital beds, physician, and other manpower in each market;
- expenditure and reimbursements and transfer payments between regional and local markets;
- procedure charges;
- utilization rates; and
- certain outcomes.

The reports would be invaluable for supporting alternative strategies for containing capacity. Information on outcomes of alternative treatment modalities, standing alone, would make a serious contribution to reducing supplier-induced demand.

³⁰ Wennberg, *op. cit.* n.1, p.9.

A PROPOSAL FOR AN ALTERNATIVE PROCEDURE TO ADJUDICATE MALPRACTICE CLAIMS

The Problem

The increasing cost of malpractice insurance inflates the cost of Federal health care and health care financing programs and may reduce the availability of some types of health care. In part, this increasing cost is attributable to the inefficiency of the civil judicial system, the high cost of access to that system, and the ineffectiveness of professional licensing and disciplinary bodies in policing the quality of medical care provided by their members and licensees.

Further, the existing system fails to compensate, or compensate adequately, many—possibly most—victims of medical malpractice, while very generously compensating—perhaps overcompensating—a few such victims.

The proposal described below adopts an administrative alternative to the present system of tort liability. Administrative alternatives, either as a supplement to, or replacement of, the existing system have been proposed in the Health Care Provider Liability Reform bill, based on the 1987 report of the Department of Health and Human Services' Task Force on Medical Liability and Malpractice, the Ensuring Access Through Medical Liability Reform bill, introduced in the last Congress by Senator Orrin Hatch (S. 2934, 101st Cong.), the Medicare Malpractice Dispute Resolution bill of 1990, introduced in the last Congress by Rep. Nancy Johnson of Connecticut. The American Medical Association's Medical Liability Project, in its January 1988 report entitled "A Fault-Based, Administrative System," also recommends adoption of an administrative model.

In developing the proposal, the following approaches to medical malpractice litigation were considered.

The Health Care Provider Liability Reform Act

Based on the 1987 report of the Department of Health and Human Services' Task Force on Medical Liability and Malpractice, the Health Care Provider Liability Reform Act offers a comprehensive solution to malpractice claims abuses. Proposed as a model act, the bill continues to await action by the several States. Because widespread adoption of the act seems unlikely in the immediate future, the act does not offer a reasonably prompt solution to the malpractice problem and, in the best of foreseeable circumstances, will provide only piecemeal reform.

The Ensuring Access Through Medical Liability Reform Act

Introduced in the last Congress by Senator Hatch (S. 2934, 101st Cong.) the "Ensuring Access Through Medical Liability Reform Act," as with the Task Force bill, attempts a global approach to the full range of malpractice claims. Also like the Task Force bill, the Hatch bill depends, in large part, upon the creation of alternative dispute resolution systems by individual States. Beyond this, however, it seeks to impose national standards on the adjudication of all malpractice claims, even though many, perhaps most, of those claims arise from treatment unconnected to any Federal program. This degree of Federal intrusiveness, as it will surely be termed by its critics, seems certain to impede the bill's prospects for enactment. In addition, the bill would establish a variety of new grant programs that, given the recent amendments to the Gramm-Rudman-Hollings law, Congress would have difficulty in funding.

The Medicare Malpractice Dispute Resolution Act of 1990

Also introduced in the last Congress, the "Medicare Malpractice Dispute Resolution Act of 1990" (Rep. Johnson of Connecticut) covers only malpractice claims by Medicare beneficiaries. As in the case of the previously described proposals, the bill would involve States in the establishment of statewide Medical Services Dispute Resolution Organizations, which would function within a malpractice arbitration system guided by the Secretary of Health and Human Services.

The instant proposal takes some of its direction from the Johnson bill. It differs, nevertheless, in two fundamental ways. First, it is based on the premise that better policy calls for one organization to apply uniform national standards to resolving the claims of Federal beneficiaries as to their treatment under a Federal direct care or federally financed program. Second, it would apply to all Federal beneficiaries.

The proposal is divided into two parts: a Federal Beneficiary Malpractice Adjudication Act and a Model State Malpractice Adjudication Act. These are described below.

The Federal Beneficiary Malpractice Adjudication Act

In General

The Federal Beneficiary Adjudication Act would establish a national administrative tribunal to hear malpractice claims arising from the medical care of Federal beneficiaries, i.e., individuals entitled to receive or be reimbursed for health care from the Federal Government. Using expeditious procedures, the tribunal would award a prevailing claimant compensation for economic losses resulting from physical harm caused by negligent treatment,

and reasonable attorney fees. By enabling an individual to obtain prompt resolution of a medical malpractice claim against a health professional or other health care provider, the Act may also be expected to encourage prompt and effective pre-hearing mediation and settlement.

This remedy would be the exclusive remedy available to Federal beneficiaries under State and Federal law.

The proposal would continue to allow the award of noneconomic damages for medical malpractice, but not to exceed \$200,000 per claimant. It would abolish derivative damages, such as a spouse's right to damages for loss of consortium.

The proposal would also require the Agency for Health Care Policy and Research, a component of the Public Health Service, to survey medical literature in order to develop practice parameters, i.e., formal guidance to physicians and other health professionals as to the best contemporary health care practice. The parameters would be of use to the tribunal in evaluating claims of malpractice under the program.

The Secretary would inform the pertinent State medical associations and licensure authorities of the tribunal's findings in each case. The Secretary would also be empowered to disallow a health professional or other health care provider from providing health care services under a Federal program and from being compensated for future services to Federal beneficiaries if repeated or extreme malpractice had characterized prior services.

Administrative Structure

Office of Malpractice Adjudication. The Act would establish, within the Department of Health and Human Services, an Office of Malpractice Adjudication (the "Office"). The Director of the Office would report to the Secretary or the Secretary's designee.

Administrative tribunal. Each malpractice claim would be heard by an administrative tribunal consisting of a presiding officer, who would be an administrative law judge meeting the qualifications for hearing examiners established by the Administrative Procedure Act, and two individuals determined by the Secretary to be expert in the field of health care or health care management. A decision of the tribunal would be by majority vote. Panels of the tribunal would be located in major population centers throughout the United States for the purpose of hearing malpractice claims against health professionals, and other health care providers, who provided health care wholly or partially paid for by a Federal program.

Administrative appeal. A party would be entitled to appeal a final determination of a tribunal to an administrative appeal council, a panel of which would be established within each region of the Department. The panel would be required to accept the tribunal's findings of fact, unless arbitrary, capricious, or unreasonable. The appeals council would be obligated to hear and decide the appeal within 4 months after the tribunal's decision.

Appeal to United States Courts of Appeal. The judgment of the appeals council could be appealed, on matters of law, to the United States court of appeal for the circuit within which the malpractice claim arose. The court would be without jurisdiction to reexamine findings of fact affirmed on administrative appeal, although it could remand the case to the agency with instructions to find additional facts. The court would be required to affirm the judgment of the appeals council unless it were found to be arbitrary, capricious, or unreasonable.

Claims Adjudication Procedure

In general. Procedures for the adjudication of malpractice claims would be established by the Secretary's regulations, subject to these constraints:

Time for adjudication. A claim would be heard, after allowing such continuances as the administrative tribunal may find proper, within 6 months of filing, and a decision rendered within 2 weeks after hearing.

Discovery. Discovery would be freely granted, in conformity with the Federal Rules of Civil Procedure.

Subpoenas. Subpoenas would run within the United States, except that a party subpoenaed outside the State in which the hearing is held could apply to a United States district court for relief on the grounds of hardship.

Enforcement of order. The violation of a proper order of a tribunal under the Act would be punishable as a contempt in the United States district court for the district in which the hearing is scheduled to be held.

Record; evidence. A tribunal would decide a claim on the record before it but would receive such evidence as it finds credible and give that evidence such weight as it may find appropriate.

Form of decision. The decision of the tribunal would be in writing, would recite findings of fact and conclusions of law, and would be prepared after all parties have had the opportunity to present their cases in the presence of each other.

Enforcement of judgment. A judgment of the tribunal would be limited to an award of money and would be enforceable by a United States district court.

The Judgment

Economic loss. A judgment for the claimant under the Act would be for the claimant's past, present, and future economic loss resulting from physical injury attributable to malpractice.

Collateral source reduction.

Amounts not deriving from a Federal program. A judgment would be reduced by any insurance or other amount to which the claimant became entitled in compensation of illness or injury resulting from the claimed malpractice (except amounts deriving from a Federal program).

Amounts deriving from a Federal program. A judgment would be reduced by one-half of any amount deriving from a Federal program. In such case a supplementary judgment would be issued in favor of the United States for the balance of the payments. In the case of Medicare, this latter amount would, upon payment, be credited to the pertinent Medicare trust fund. In the case of a Federal direct care program, the amount would be deposited in the general fund of the treasury. In the case of a federally assisted State program, the money would be divided, as appropriate, between the general fund of the treasury and the State.

Noneconomic damages. Noneconomic damages, such as pain and suffering, would be limited to \$200,000. Derivative damages, such as a spouse's claim for pain and suffering, would be abolished.

Attorney's fees. A judgment for the claimant would include an amount for attorney's fees, in accordance with a schedule established by regulation within a ceiling set by the statute. The proposed ceiling is 25 percent of the first \$100,000, 15 percent of the next \$200,000, and 10 percent of the remainder.

Costs of proceeding. The tribunal could, in its discretion, assess either or all parties an amount, established by regulation and payable to the general fund of the Treasury, equivalent to all or part of the administrative costs of the proceeding. As appropriate, costs would be assessed so as to discourage frivolous proceedings.

Comparative negligence. An award for the claimant would be reduced in proportion to the degree to which the tribunal found that the claimant's negligence had contributed to the injury.

Liability of parties defendant. If there are two or more parties defendant, they would not be jointly liable. A judgment against a party defendant would be limited to that party's proportionate share of the injury caused.

Award for future economic loss. An award for future economic loss would not require the payment, within a calendar year, of an amount that exceeded the loss anticipated for that year, but such award would not be subject to future adjustment.

Derivative rights. No award could be made to any party based upon injury caused by malpractice in the medical treatment of some other person.

Exclusions

The Office would be without the power to adjudicate a malpractice claim alleging:

- Wrongful death or
- Willful injury.

Exclusivity of Remedy

Except as otherwise provided by this Act, no court of any State, or of the United States, would have jurisdiction to adjudicate any claim arising from or alleging malpractice if that claim were cognizable under this Act. In other words, the Act would be the exclusive avenue available to Federal beneficiaries for pressing malpractice claims.

Notification

Notification of State and local agencies and organizations. In every case of malpractice, the Act would require the Secretary to transmit the final judgment of the tribunal to the pertinent State medical or health professional society and the State professional licensure or certification authority.

Notification of Health Care Financing Administration. The Office would transmit every decision of the tribunal and the administrative appeal council to the Health Care Financing Administration for its use in peer review or otherwise, as HCFA may determine.

Debarment

The Act would require the Secretary to review each case in which malpractice was found. In any case in which the Secretary determined there had been gross negligence, or a health professional or other health care provider had been responsible for repeated instances of malpractice, the Secretary, after opportunity for hearing, could bar the health professional or other health care provider from treating Federal beneficiaries or from receiving compensation for any care rendered by that health professional or other health care provider to a Federal beneficiary and would notify the pertinent State medical or health professional society and the State professional licensure or certification authority.

Practice Parameters

The Act would direct the Agency for Health Care Policy and Research to develop health care practice parameters, i.e., formal guidance to physicians and other health professionals, based on a comprehensive survey of medical literature, as to the best contemporary health care practice. The tribunal would use the parameters as a screening device in evaluating claims of malpractice, not as a means of differentiating good care from bad care.

Model State Malpractice Adjudication Act

In General

This part outlines specifications for a model State statute, the State Malpractice Adjudication Act, to be prepared within the Department of Health and Human Services in consultation with the States, intended to deal with those claims of medical malpractice not addressed by the Federal Beneficiary Malpractice Adjudication Act. Like the proposed Federal act, the model State act would seek to restrain further growth in the cost of malpractice insurance, which has both inflated the cost of medical care and reduced the availability of health care in some medical specialties.

The proposal follows the outlines of the Federal Beneficiary Malpractice Adjudication Act proposal. It would establish a State administrative adjudication mechanism to hear malpractice claims arising under State law. It would enable a claimant to obtain prompt resolution of a medical malpractice claim against a health professional or other health care provider over whom the State courts have jurisdiction. A prevailing claimant would be awarded compensation for economic losses resulting from physical harm caused by negligent treatment, and reasonable attorney fees.

This remedy would be the exclusive remedy available to a claimant under State law for medical malpractice.

The proposal would continue to allow the award of noneconomic damages, but not to exceed \$200,000 per claimant. It would abolish derivative damages, such as a wife's right to damages for loss of consortium.

Also, the proposal would establish a State Advisory Council on Standards of Health Care to develop guidelines for use in evaluating claims of malpractice under the program.

The Secretary of Health and Human Services would develop a Model State Act on the Adjudication of Malpractice Claims. Major features of the Act follow.

Administrative Structure

Office of Medical Malpractice Adjudication. The Act would establish within the State an Office of Malpractice Adjudication (the "Office"). The Director of the Office would report to the Governor or such subordinate official as the Governor may designate.

Employment of hearing examiners. The Office would employ hearing examiners, located in major population centers within the State, to hear malpractice claims against health professionals and other health care providers over whom the courts of the State would have jurisdiction.

Administrative appeal. The Office would contain an administrative appellate tribunal to hear and promptly resolve administrative appeals from the judgment of a hearing examiner.

Claims Adjudication Procedure

In general. Procedures for the adjudication of malpractice claims would be established by regulations of the Office, subject to these constraints:

- ***Time for adjudication.*** A claim would be heard, after allowing such continuances as the hearing examiner may find proper, within 6 months of filing, and a decision rendered within 2 weeks after hearing.
- ***Discovery.*** Discovery would be freely granted.
- ***Subpoenas.*** Subpoenas would run within the State.

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- ***Enforcement of order.*** The violation of a proper order of a hearing examiner under the Act would be punishable as a contempt in any court of the State.
 - ***Record; evidence.*** A hearing examiner would decide a claim on the record before him, but would receive such evidence as he finds credible, for such weight as may be appropriate.
 - ***Form of decision.*** The decision of the hearing examiner would be in writing, would recite findings of fact and conclusions of law, and would be prepared after all parties have had the opportunity to present their case in the presence of each other.
 - ***Enforcement of judgment.*** A judgment of the hearing examiner would be limited to an award of money and would be enforceable by the court.

Malpractice Defined

Malpractice, for purposes of this Act, would include injury or illness associated with a given course of treatment, even if not arising from its negligent provision, if the injury or illness were a known risk of the treatment provided and the health care professional or other health care provider had failed fully to inform the claimant of such risk.

The Judgment

Economic loss. A judgment for the claimant under the Act would be for the claimant's past, present, and future economic loss resulting from physical injury attributable to medical malpractice.

Collateral source reduction.

Amounts not deriving from Medicare or Medicaid. A judgment would be reduced by any insurance or other amount to which the claimant became entitled in compensation of illness or injury resulting from the claimed malpractice (except amounts deriving from Medicare or Medicaid).

Amounts deriving from Medicare or Medicaid. A judgment would be reduced by one-half of any amount deriving from Medicare or Medicaid. In such case a supplementary judgment would be issued in favor of the United States for the balance of the Medicare or Medicaid payments, which amount would, upon payment, be credited to the pertinent Medicare trust fund or the Medicaid appropriation, as applicable. The Department of Health and Human Services would thereafter pay over to a State so much of the payment attributable to Medicaid as represents the State's share of that payment.

Noneconomic damages. Noneconomic damages, such as pain and suffering would be limited to \$200,000. Derivative damages, such as a wife's claim for pain and suffering, would be abolished.

Attorney's fees. A judgment for the claimant would include an amount for attorney's fees, in accordance with a schedule established by the Office within a ceiling set by the Act. The proposed ceiling is 25 percent of the first \$100,000, 15 percent of the next \$200,000, and 10 percent of the remainder.

Costs of proceeding. The hearing examiner could, in his discretion, assess either or all parties an amount, established by regulation and payable to the State, equivalent to all or part of the administrative costs of the proceeding.

Comparative negligence. An award for the claimant would be reduced in proportion to the degree to which the hearing examiner found that the claimant's negligence had contributed to the injury.

Liability of parties defendant. If there are two or more parties defendant, they would not be jointly liable. A judgment against a party defendant would be limited to that party's proportionate share of the injury caused.

Award for future economic loss. An award for future economic loss would not require the payment, within a calendar year, of an amount that exceeded the loss anticipated for that year; but such award would not be subject to future adjustment.

Derivative rights. No award could be made to any party based upon injury caused by malpractice in the medical treatment of some other person.

Administrative Appeal

A party would be entitled to appeal a final determination of a hearing examiner to an appellate tribunal established by the Office. The tribunal would be required to hear and decide the appeal within 4 months after that determination.

Appeal to State Appellate Court

The judgment of the appeals council could be appealed to the appropriate State court of appeals.

- The court would not have jurisdiction to reexamine any administrative finding of fact, although it could remand the case to the agency with instructions to find additional facts.
- The court would be required to affirm the judgment of the appeals council unless it were found to be arbitrary, capricious, or unreasonable.

Exclusions

The Office would be without the power to adjudicate a malpractice claim alleging:

- Wrongful death or
- Willful injury.

Exclusivity of Remedy

Except as otherwise provided by this Act, no other court would have jurisdiction to adjudicate any claim arising from, or alleging, medical malpractice if that claim were cognizable under this Act. In other words, the Act would be the exclusive avenue available for pressing malpractice claims within the state.

Licensing and Relicensing

The appropriate State licensing body would be required to review each case in which malpractice were found. In any case in which it determined there had been gross negligence, or a health professional or other health care provider had been responsible for repeated instances of malpractice, it would be authorized, after opportunity for hearing, to suspend or revoke the license of the professional or other health care provider to provide health care services within the State, or to direct (in the case of a health care professional) that the individual submit to a relicensing examination.

Advisory Council on Standards of Health Care

The bill would establish an Advisory Council on Standards of Health Care to develop guidelines for use in evaluating claims of malpractice under the program.

Establishment of Council panels; appointment of members. The Director of the Office would establish panels of the Council to advise on various aspects of health care, including medical and surgical practice, and nursing care, and, in consultation with the appropriate professional licensing bodies and professional associations concerned with the provision of health care within the State, would appoint to these panels distinguished members of the health care professions.

Development of practice guidelines. Each panel would develop for the Council, and the Council would recommend to the Director, guidelines for use in evaluating the quality and appropriateness of health care with respect to the various medical conditions. The Director would publish the guidelines, and they would be available as a resource to the Office in adjudicating malpractice claims filed with it.

Adoption of Model Act; Application of Federal Act to Non-Federal Beneficiaries

If a State adopts the Malpractice Adjudication Act before Congress enacts the Federal Beneficiary Malpractice Adjudication Act, the State statute would apply to all Federal beneficiaries and health care professionals and other health care providers over whom the State has jurisdiction, until enactment of the Federal act. If a State does not adopt the Malpractice Adjudication Act within 5 years after the Secretary promulgates it, and Congress has enacted the Federal Beneficiary Malpractice Adjudication Act, the Federal act would be opened to all malpractice claims arising in the State, at the option of either party.

A PROPOSAL TO CONTAIN MEDICARE COSTS THROUGH USE OF SELECTIVE CONTRACTING

Purpose of the Proposal

It is proposed to institute a system, under Medicare, whereby the program will reimburse a provider for the costs of performing a designated medical or surgical procedure—a procedure typified by its high cost to the program, such as a coronary artery bypass operation—only if Medicare has first approved the provider for the performance of that procedure. The proposal's objective is to channel patients for those procedures to facilities that provide cost-efficient, quality services.

Elements of the Proposal

Procedures Designated

The Secretary of Health and Human Services may designate a medical or surgical procedure the performance of which will be reimbursed by Medicare only if performed at an approved facility, if:

- the Secretary determines that the procedure is one that imposes high costs on the Medicare program, and
- the Office of Health Technology Assessment of the Public Health Service has assessed the procedure and found it to be safe, effective, and necessary to alleviate a life-threatening or seriously disabling condition.

Qualification of Facility

Competitive bidding. The Secretary would be required to develop administrative arrangements under which criteria would be published for the selection of facilities to perform each procedure designated under the program, and bids from such facilities would be solicited and evaluated.

Fixed charge. All services delivered by a provider would be on the basis of a fixed charge per procedure for all hospital and physician services (including postoperative care) associated with the procedure, regardless of the actual cost of the procedure in a particular case.

Quality Assurance Standards

To be approved as a facility for the performance of a procedure under this proposal, the facility must meet the following criteria:

- **Patient selection.** It must have written patient selection criteria which it would follow in determining suitable candidates for the procedure. Patient selection criteria must be based upon both a critical medical need for the procedure and a maximum likelihood of successful clinical outcome.
- **Patient management.** It must have adequate patient management plans and protocols that include the following:
 - *Therapeutic and evaluative procedures.* Therapeutic and evaluative procedures for the acute and long-term management of a patient, including commonly encountered complications.
 - *Patient management and evaluation.* Patient management and evaluation during the waiting and immediate postdischarge period

as well as in-hospital phases of the program for performing the procedure.

- *Long-term management and evaluation.* Long-term management and evaluation, including education of the patient, liaison with the patient's attending physician, and the maintenance of active patient records for at least 5 years.
- **Commitment.** A facility must make a sufficient commitment of resources and planning to the program for performing the procedure to carry through its application. Indications of this commitment should include the following:
 - *Commitment at all levels.* Commitment of the facility to the program at all levels, including, as necessary, other departments of the facility as well as the principal sponsoring departments.
 - *Adequate expertise.* The facility is expert in medical, surgical, and other relevant areas, including an identifiable and stable team for performing the procedure, the responsible members of which are board certified or otherwise approved by the Secretary.
- **Facility plans.** The facility must have overall facility plans, commitments, and resources for a program that will ensure a reasonable concentration of experience. The Secretary of Health and Human Services would establish the frequency with which the facility must perform the procedure for the conditions for which it is indicated. This level of activity must be shown feasible and likely on the basis of plans, commitments, and resources.
- **Experience and survival rates.** The facility must demonstrate experience and success with the procedure. Survival rates must meet criteria established by the Secretary.

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- **Maintenance of data.** The facility must agree to maintain and, when requested, periodically submit data to the Secretary, in standard format, about patients selected (including patient identifiers), protocols used, and short- and long-term outcome on all patients who undergo the procedure, not only those for whom payment under Medicare is sought.
 - **Laboratory services.** The facility must make available, directly or under arrangements, laboratory services (including blood banking) to meet the needs of patients. Laboratory services must be performed in a laboratory facility approved for participation in the Medicare program.

Reimbursement of Beneficiary

In addition to such other reimbursement as the Medicare statute may provide, a beneficiary may be reimbursed for travel to and from a designated facility if the beneficiary resides more than 50 miles from the facility.

Patient Information

The Health Care Financing Administration, in consultation with the Social Security Administration, would design and adopt procedures:

- to inform individuals eligible for Medicare of the existence of facilities that provide cost-efficient, quality services; and
- to assist those individuals to tap into existing provider networks, such as PPO plans, from which they can obtain information as to the availability of services from such facilities.

A PROPOSAL TO ESTABLISH CENTERS OF EXCELLENCE

Purpose of the Proposal

It is proposed to reimburse health care providers, under Medicare, for the costs of performing designated major surgical procedures, only if those procedures are performed in facilities—termed "Centers of Excellence"—meeting rigorous criteria of quality. The procedures would be those that are not frequently performed by most institutions because of infrequent occurrences in terms of incidence and prevalence. Such procedures normally require the use of highly specialized techniques employed by a skilled and highly trained team of physicians and nurses and are necessary for life-threatening or seriously disabling conditions. Examples include heart, liver, or lung transplants.

Because the number of procedures performed has a direct bearing on the success rate, the proposal's objective is twofold: to encourage patients to seek procedures at facilities most successful in performing them and to discourage the performance of these procedures at facilities less successful in performing them.

Because a consequence of the proposal would be to reduce the number of facilities at which the designated procedures could be performed, a major feature would be to reimburse the Medicare beneficiary for the cost of travel between the facility and the residence.

Elements of the Proposal

Procedures Designated

In order to be designated as a procedure the performance of which will be reimbursed by Medicare only if performed at a Center of Excellence, a procedure must meet these criteria:

- It is not frequently performed by most institutions.
- It requires the use of highly specialized techniques employed, in most cases, by a skilled and highly trained team of physicians and nurses.
- It is critically necessary for life-threatening or seriously disabling conditions.

Procedure Designation Process

The Secretary of Health and Human Services would establish an initial list of such procedures and would be authorized to add procedures as appropriate. Each procedure on the list must first be assessed by the Office of Health Technology Assessment of the Public Health Service and found to be safe, effective, and necessary to alleviate a life-threatening or seriously disabling condition.

Criteria for Designation as Center of Excellence

To be designated as a Center of Excellence for a designated procedure, the facility must meet the following criteria:

- **Patient selection.** It must have written patient selection criteria that it would follow in determining suitable candidates for the procedure. Patient selection criteria must be based upon both a critical medical

need for the procedure and a maximum likelihood of successful clinical outcome.

- **Patient management.** It must have adequate patient management plans and protocols that include the following:
 - *Therapeutic and evaluative procedures.* Therapeutic and evaluative procedures for the acute and long-term management of a patient, including commonly encountered complications.
 - *Patient management and evaluation.* Patient management and evaluation during the waiting and immediate postdischarge period as well as in-hospital phases of the program for performing the procedure.
 - *Long-term management and evaluation.* Long-term management and evaluation, including education of the patient, liaison with the patient's attending physician, and the maintenance of active patient records for at least 5 years.
- **Commitment.** A facility must make a sufficient commitment of resources and planning to the program for performing the procedure to carry through its application, including a significant referral pattern. Indications of this commitment should include the following:
 - *Commitment at all levels.* Commitment of the facility to the program at all levels, including, as necessary, other departments of the facility as well as the principal sponsoring departments in order to provide a full spectrum of supportive care.
 - *Adequate expertise.* The facility is expert in medical, surgical, and other relevant areas, including an identifiable and stable team for

performing the procedure, the responsible members of which are board certified or otherwise approved by the Secretary.

- **Integration of teams.** The component teams must be integrated into a comprehensive team with clearly defined leadership and corresponding responsibility.
- **Anesthesia.** The anesthesia service must identify a team for performance of the procedure that is available at all times.
- **Infectious disease.** The infectious disease service must have both the professional skills and laboratory resources needed to discover, identify, and manage the complications from a whole range of organisms, many of which are uncommonly encountered.
- **Nursing service.** The nursing service must identify a team or teams trained in the special problems of managing patients who undergo the procedure.
- **Pathology resources.** Pathology resources must be available for studying and reporting promptly any pathological responses to the procedure.
- **Social services.** Adequate social services resources must be available.
- **Patient selection.** Mechanisms must be in place to ensure that:
 - patient selection criteria are consistent with those set forth in the facility's written patient selection criteria, and

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- the facility is responsible for the ethical and medical considerations involved in the patient selection process and application of patient selection criteria.
 - **Plans for organ transplantation.** If the procedure involves organ transplantation, that adequate plans exist for organ procurement meeting legal and ethical criteria, as well as yielding viable transplantable organs in reasonable numbers.
 - **Facility plans.** The facility must have overall facility plans, commitments, and resources for a program that will ensure a reasonable concentration of experience. The Secretary of Health and Human Services would establish the frequency with which the facility must perform the procedure for the conditions for which it is indicated. This level of activity must be shown feasible and likely on the basis of plans, commitments, and resources.
 - **Experience and survival rates.** The facility must demonstrate experience and success with the procedure and be in the forefront of medicine for the specific specialty. Survival rates must meet criteria established by the Secretary. The facility should be evaluated periodically.
 - **Maintenance of data.** The facility must agree to maintain and, when requested, periodically submit data to the Secretary, in standard format, about patients selected (including patient identifiers), protocols used, and short- and long-term outcome on all patients who undergo the procedure, not only those for whom payment under Medicare is sought.
 - **Laboratory services.** The facility must make available, directly or under arrangements, laboratory services (including blood banking) to meet the needs of patients. Laboratory services must be performed in

a laboratory facility approved for participation in the Medicare program.

Reimbursement of Beneficiary

In addition to such other reimbursement as the Medicare statute may provide, a beneficiary may be reimbursed for travel to and from a Center of Excellence if the beneficiary resides more than 50 miles from the Center.

PROMOTING HEALTHY LIFESTYLES

The Problem

A substantial amount of research has been done that demonstrates the impact of certain lifestyle behaviors, such as smoking, alcohol and drug abuse, improper nutrition, lack of exercise and physical activity, and stressful occupations, on longevity and quality of life. Substantial efforts have also been made by the government and public and private agencies to disseminate this information to the public in order to encourage changes in lifestyle behaviors that impact health status. As a result of these efforts, many Americans have made substantial changes in their lifestyle behaviors. For example, the national campaign against cholesterol has resulted in many Americans changing their eating behaviors.

Despite these successes, more needs to be done to increase the awareness of Americans as to the impact on health of making correct lifestyle choices. A grassroots level campaign is needed to educate Americans through activities with schools, clubs, community groups, voluntary organizations, businesses, labor organizations, government, and societies of health professionals.

The Proposal

Measures to Discourage the Use of Tobacco

Advertising ban. The proposal would ban all forms of advertising tobacco and tobacco products.

Vending machine ban. The proposal would ban the sale of cigarettes from vending machines.

Termination of tobacco subsidy. The proposal would phase out tobacco subsidies under a program that would offer farmers loans and other short-term assistance to facilitate conversion to other crops.

Encouraging Healthy Lifestyles

The proposal³¹ would establish a statutory foundation for the development and implementation of programs to encourage healthy lifestyle choices, such as:

- avoiding illegal drugs;
- avoiding excessive alcohol consumption;
- avoiding the use of tobacco products;
- choosing proper foods as components of a healthy, balanced diet;
- developing effective ways to manage stress; and
- engaging in regular exercise.

Use of Current Programs and Activities

The administering agency would promote this new concept of physical fitness by:

- enlisting the active support of private citizens, civic groups, business enterprises, foundations, and other entities in efforts to promote healthy lifestyle choices by all Americans;

³¹ One approach might be to reconstitute the President's Council on Physical Fitness and Sports as a statutory body and expand its functions.

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- initiating activities to inform the general public of the importance of healthy lifestyle choices and the link between appropriate lifestyle behaviors and good health and productivity;
 - encouraging State and local governments to emphasize to their citizens the importance of making healthy lifestyle choices;
 - advancing the concept of physical fitness through healthy lifestyle choices by systematically encouraging the development of community programs;
 - developing cooperative programs with societies of health professionals to encourage Americans to make healthy lifestyle choices;
 - assisting educational agencies at all levels to develop high-quality, innovative health and physical education programs that emphasize the importance of making the right lifestyle choices for good health; and
 - helping business, industry, government, and labor organizations by encouraging public/private ventures to establish programs to promote healthy lifestyle choices among their employees and to reduce the financial and human costs resulting from inappropriate lifestyle choices.³²

³² The new program would assume the current activities of the President's Council on Physical Fitness and Sports are directed only toward exercise and sports, i.e., promotion of research in sports medicine, physical fitness, and sports performance, and coordinating Federal agency activities relating to physical fitness and sports. This would be accomplished by expanding the mission of the Council to enable it to administer the proposal, transferring the Council to the agency administering the proposal, or abolishing the Council altogether.

PRESIDENT'S COUNCIL ON FITNESS FOR THE SECOND FIFTY YEARS

The Problem

In its report, "The Second Fifty Years: Promoting Health and Preventing Disability," the Institute of Medicine wrote:

Health research, education, and service policies are often written as though our older generations are beyond help. Although there is sufficient evidence of the benefits of health promotion and disability prevention among older individuals, many of them are not advised to stop smoking, to begin exercising, to be screened for various forms of cancer, or to be immunized against infectious diseases. . . . To accommodate the changing needs of an increasingly older society we must add several imperatives: we must promote health throughout life, and we must also prevent the ill from becoming disabled and help the disabled to prevent further disability.

These observations gain an added significance when it is appreciated that the first baby boomers will turn 50 in 1997.

Yet, as the American Medical Association observes:

. . . most middle-aged adults do very little in the way of physical exercise. . . . In part, this widespread inactivity stems from the mythology that surrounds the issues of exercise and aging. As people grow older, they tend to believe that their need for physical activity

diminishes and they tend to exaggerate the risks involved in vigorous exercise after middle age.³³

Predictably, most people enter their middle and senior years with a needlessly limited ability to carry out, with alertness and vigor, the critical tasks of daily living.

Medical experts agree that many of the physical changes that people attribute to normal aging actually are a result of inactivity and could be diminished by a continuing program of physical exercise.³⁴

Studies have found that people who exercise regularly have a lower incidence of cardiovascular disease.³⁵

Although the President's Council on Physical Fitness and Sports has not neglected this age group, that Council's excellent programs appeal primarily to the young.

The Proposal

In General

It is proposed that there be established, as a companion body to the President's Council on Physical Fitness and Sports, a President's Council on Fitness for the Middle and Senior Years, which shall be within the Department of Health and Human Services. The Council shall focus on the

³³ The American Medical Association, *Health and Well-Being After 50*, 1984, p. 149.

³⁴ Dartmouth Institute for Better Health, *Medical and Health Guide*, 1986, p. 51.

³⁵ The Columbia University School of Public Health, *Complete Guide to Health and Well-Being After 50*, 1988, p. 154.

development of programs especially suited to an individual's middle and later years.

Appointment

The President shall appoint 20 members to the Council and shall designate a Chairman and Vice Chairman.

National Program

The Council shall:

- enlist the active support and assistance of individual citizens, civic groups, private enterprise, voluntary organizations, and others in efforts to promote and improve the fitness of all Americans over age 50 through regular participation in suitable programs of physical fitness;
- initiate programs to inform the general public of the importance of exercise and the link that exists between regular physical activity and good health and effective performance;
- strengthen coordination of Federal services and programs relating to physical fitness of individuals over age 50;
- encourage State and local governments to emphasize the importance of regular physical fitness for older citizens;
- encourage research in physical fitness for older individuals; and
- assist business, industry, government, and labor organizations to establish sound physical fitness programs to reduce the financial and human costs of physical inactivity.

Coordination

The Council shall seek to coordinate its activities with those of the President's Council on Physical Fitness and Sports.

Other Functions

The Council shall advise the President and the Secretary of Health and Human Services as to its activities in devising and promoting programs to improve the fitness of older Americans and evaluate the effectiveness of those programs.

Service of Members

The members of the Council shall serve without compensation for their work on the Council but will be entitled to travel and subsistence expenses for meetings.

Staff

The Secretary of Health and Human Services shall provide the Council with a suitable staff and facilities.

RESEARCH TO FOSTER INDEPENDENT LIVING

The Problem

Many diseases or other conditions lead to chronic disability: dementia, arthritis, vascular diseases, hip and other fractures, hypertension, diabetes, cancer, and emphysema among them. Most of these diseases do not generally lead to high mortality.³⁶ Instead, they leave in their wake individuals unable to perform many of the activities of daily living and therefore in need of long-term care.

One generally needs long-term care, regardless of its setting, if one experiences limitations in one or more of five activities necessary for daily living: eating, continence, mobility, bathing, or dressing. Those not suffering severely from these limitations may nevertheless need help in performing instrumental tasks for daily living: shopping, cooking, and performing chores.³⁷

Much research is being done into the underlying causes of the diseases that lead to these disabilities, but insufficient research has been done either to correct the disability and return the individual to normal functioning or to assist the afflicted individual in dealing with the disability. As a result, nursing home care remains the leading cause of uninsured catastrophic expenditures paid by the elderly.³⁸

³⁶U.S. Department of Health and Human Services. Technical Work Group on Private Financing of Long-Term Care for the Elderly, "Report to the Secretary on Private Financing of Long-Term Care for the Elderly," November 1986, p. vi.

³⁷ *Ibid.*, p. 2-5 & 2-6.

³⁸ *Op. cit.* n.1, p.i.

Although the majority of those unable to perform some the activities of daily living do not become institutionalized, for many a problem such as incontinence will require nursing home placement. The elderly nursing home population—persons age 65 and older—is expected to grow to 2.1 million by the year 2000, and to 4.4 million by the year 2040.³⁹ In part, this reflects increasing lifespan. "In [the decades] 1990 to 2010, the group age 85 and over will increase three to four times as fast as the general population."⁴⁰ Of those over the age of 85, almost one-quarter is institutionalized.⁴¹ More than 20 percent of elderly persons will stay in a nursing home at least 1 year, at an average annual cost in excess of \$30,000 a year.

Permanent institutionalization severs a person's ties to the community, contributing to the depression and demoralization that may afflict one's declining years. Although nursing home care is for most people the least desirable alternative to providing for themselves in old age, increasing numbers of the population will be compelled in the coming years to avail themselves of it.

The Home- and Community-Based Option

Today, most long-term care—71 percent—is provided in the home or community, much of it by family and friends at no cost to others.⁴² It is the least disruptive to patterns of living built up over a lifetime.⁴³ In

³⁹ Manton, K.G. and Liu, K., "The Future Growth of the Long-Term Care Population," paper presented at Hillhaven Foundation's Third National Leadership Conference on Long-Term Care Issues, Washington, DC, March 7-9, 1984.

⁴⁰ Ibid.

⁴¹ Op. cit. n. 1, p. 1-2.

⁴² Op. cit. n.1, p. iii.

⁴³ Home- and community-based long-term care encompasses the following services: service-enriched sheltered housing; home-delivered professional nursing and therapy services; nonprofessional home health aide and personal care services; homemaker/chore services; daycare for the elderly or mentally ill; habilitation services for the mentally retarded or developmentally disabled; home-delivered and congregate

general, it is the option of choice. But it is an option denied to many whose disabilities or lack of family or friends prevent them from electing it.

Because the Federal Government possesses a unique resource in the National Institute on Aging, it can contribute to State, local, and private efforts to reduce institutionalizing the elderly. At present, the Institute, organizationally part of the National Institutes of Health, primarily engages in basic research, and the support of basic research, into the aging mechanism and problems associated with aging. But unlike the other institutes, the NIA's mission has enabled it to perform research outside of the biomedical field.

The Proposal

Establishment of Center

The proposal would expand the focus of the National Institute on Aging (NIA) by establishing within it a Center for Fostering Independent Living. The Director of the Center would report directly to the NIA director.

Mission, in General

The Center would conduct and support applied research into means, social and scientific, to foster independent living among persons suffering an impairment in their ability to perform activities of daily living. Given its organizational placement, the Center would have ready access to the scientific findings of NIA as well as the other NIH institutes.

meals; case management, assessment, and referral services; home adaptations; transportation; friendly visiting; and surveillance services. *Op. cit.*, n.1, pp. 2-16 & 2-17.

Functional Assessment and Evaluation of Therapies

The Center would encourage the development of improved methods of assessing the ability of impaired individuals to function in a noninstitutional setting and would undertake an evaluation of the effectiveness of existing rehabilitative therapies.

Alleviation of Disabling Conditions

Continuing technological advances provide a means for dealing with the disabilities often associated with aging and which frequently lead to the need for long-term care.⁴⁴ The Center, in cooperation and consultation with the Food and Drug Administration, would support the development and availability of drugs and devices such as those to:

- eliminate falls or reduce their effect,
- alleviate severe hearing or vision losses,
- treat or correct urinary incontinence,
- aid memory so as to combat wandering behavior and other severe consequences of memory deficits, and
- compensate for losses in mobility.

⁴⁴ Op. cit. n.1, p. 2-58.

Living Arrangements

The Center would:

- survey various living arrangements that would permit an individual employing them to live independently,
- develop or support ways to optimize those living arrangements, and
- conduct, or support the conduct of, one or more demonstrations of various living arrangements (except that no such demonstration may subsidize the living arrangements or care of any individual).

Guide to Independent Living

The Center would publish a Guide to Independent Living. The Guide would be widely distributed to the elderly and would provide them with information about medical and technological developments, home- and community-based services, and improved living arrangements, pertinent to aiding them, particularly the impaired elderly, to remain within the community.

Technical Assistance

The Center would be authorized to provide technical assistance to States, local communities, and nonprofit organizations in the development or implementation of improved arrangements to enable the elderly, particularly the impaired elderly, to live independently.

Appropriations Authorization

In order to ensure that the applied research and demonstrations conducted by the Center do not lose out to basic scientific research in the competition for limited funds, the Center would have its own appropriations authorization.

Nevertheless, the Director of the National Institutes of Health would be authorized to supplement appropriations under this authorization from other NIH appropriations, subject to such limitations as annual appropriations acts may impose.

PROPOSAL TO PROVIDE DRUG AND ALCOHOL ABUSE PREVENTION, EDUCATION, AND TREATMENT FOR PRESCHOOL AND ELEMENTARY SCHOOL CHILDREN

The Problem

Alcohol and drug abuse are serious problems in the United States today. Approximately 18 million Americans have problems resulting from alcohol abuse, and about 7 percent of drinkers experience dependence symptoms. Nine of 10 high school seniors report having used alcohol at least once.

Although the overall use of drugs has declined in recent years, the use of certain drugs—particularly crack cocaine—has increased. According to a 1988 survey conducted by the National Institute on Drug Abuse, 21 million Americans have used cocaine at least once, and 21 million also used marijuana during the preceding year. At least 263,000 drug abusers were treated in facilities in 1987.

Alcohol and drug abuse are becoming increasingly prevalent among youth. According to the 1987 National Adolescent School Health Survey, 77 percent of eighth grade students have tried alcohol and of these, 55 percent report trying it by sixth grade. Fifteen percent of eighth graders report having tried marijuana, and 44 percent of these report their first use was by sixth grade. Twenty-one percent of eighth grade students report having tried inhalants (glues, gases, and sprays), and, of these, 61 percent report their first use was by the sixth grade. Use of tobacco, which is a gateway drug to the use of alcohol and other drugs, is also a problem among youth. Fifty-one percent of

eighth grade students report having tried cigarettes, and 72 percent of these report their first use by the sixth grade or before.

Peer pressure, as well as exposure to alcohol and drugs in the home, contribute to use of alcohol and drugs by youth. A survey by *Weekly Reader* found that 38 percent of the fourth graders surveyed report peer pressure to try wine coolers, 41 percent to smoke, and 24 percent to use crack or cocaine. To counteract these influences, early prevention, education, and treatment is needed, so that our youngest children learn not to abuse alcohol and/or use drugs. In the Advisory Council's national survey, 84 percent of respondents supported the provision by school-based health centers of education and counseling for elementary school children to prevent alcohol and drug abuse.

The Proposal

The Council recommends that the Surgeon General develop a program to provide prevention, education, and where appropriate, treatment, for alcohol abuse and drug abuse affecting preschool and elementary school children. The program should include the development of educational materials that parents and teachers can use to teach preschool and elementary school children to avoid alcohol and drug abuse, efforts to encourage producers of children's television programming to include antialcohol and drug abuse themes and messages in children programs, public service announcements, and other public education campaigns directed specifically at children.

In addition, the Council recommends that school-based health centers include programs such as Ala-Tot for preschool and elementary school children in the services offered at these centers and make referrals for alcohol and drug abuse treatment for parents of preschool and elementary school children.

A PROPOSAL FOR A PUBLIC EDUCATION CAMPAIGN ON PREVENTION

The Problem

Many choices individuals make about their lifestyles—including choices about physical fitness, nutrition and diet, smoking, abuse of alcohol, abuse of drugs, and sexual behaviors—cause or place individuals at higher risk for illness or disease. Because of demands for treatment of these illnesses and diseases, health care costs increase, and there are burdens placed on the acute care delivery system. Many people make these choices without adequate knowledge of the consequences that these behaviors will have on their health.

There are many examples of how these behavioral choices result in illness and disease that are preventable. Americans generally choose a sedentary lifestyle, despite the contribution that physical activity can make in preventing and managing many illnesses and conditions, such as heart disease, hypertension, diabetes, osteoporosis, and depression, and in assisting with weight loss. Improper diet, particularly diets high in fat, are linked with coronary heart disease and atherosclerosis.

Tobacco use is another behavior that results in preventable illnesses and diseases. It accounts for one out of every six deaths, or 390,000 deaths annually, and is a major risk factor for many diseases, including chronic bronchitis and emphysema, cancers of several organs, diseases of the heart and blood vessels, respiratory infections, and stomach ulcers. Cigarette smoking is responsible for an estimated 30 percent of all U.S. cancer deaths, 87 percent of lung cancer deaths, and 21 percent of all U.S. coronary heart disease deaths. Smoking during pregnancy is estimated to cause 20 to 30 percent of low birth weight babies, 14 percent of premature deliveries, and about 10 percent of infant deaths.

Use of alcohol and other drugs by Americans is another personal behavior choice that results in preventable illness and disease. Alcohol is linked to approximately one-half of all homicides, suicides, and automobile accidents. Fetal alcohol syndrome is the leading cause of birth defects which can be prevented and affects as many as 3 of 1,000 live births. The economic costs to the Nation resulting from alcohol abuse have been estimated to be \$70 billion.

Drug abuse is widespread in the United States and has an increasingly serious impact on health status, and demands for treatment are increasing health care costs. Drug abuse increases risk of several problems, including injuries resulting from violence, the spread of the AIDS virus, and crack addiction and developmental problems in babies. From 1985 to 1989, the number of cocaine-related emergency room episodes increased from 10,231 to 41,602, with a high of 42,510 episodes in 1988. The costs of drug abuse problems to the Nation were estimated to be \$44 billion in 1990.

Almost 12 million Americans are affected by sexually transmitted diseases annually, and 86 percent of these American are between the ages of 15 and 29. The most common sexually transmitted diseases are HIV, gonorrhea, syphilis, and genital herpes. The most serious complications of sexually transmitted diseases include AIDS, pelvic inflammatory disease, sterility, blindness, infant deaths, mental retardation, and birth defects. The total cost of sexually transmitted diseases to society exceeds \$3.5 billion annually.

In addition, many Americans are unaware of the availability and benefits of preventive care, such as immunization, vision and eye tests, mammograms, and Pap smears, in reducing disease and saving lives. For example, there has been an increase in the number of cases of measles, a childhood disease that is preventable with a vaccine.

Recent efforts, such as the campaign to educate the public about cholesterol, have been successful in raising the public's awareness of how changes in

behavior and use of preventive care can reduce disease and illness. Increasing public awareness of the benefits of changing behavior and using this type of care can further reduce disease, and as a result, hold down health care costs.

The Proposal

It is proposed that the Surgeon General of the United States conduct a massive, 3-year public education campaign on the prevention of disease through changes in personal behaviors and use of preventive care and screening. The campaign would involve a coordinated effort using the broadcast and print media, including public service announcements, outreach to community groups, and cooperative ventures with businesses. The campaign would also involve schools through design of curricula for use in health education classes as well as presentations on preventive health issues.

The Council suggests that the Advertising Council adopt this public education campaign on prevention as its entire effort during this 3-year period and that the Surgeon General work with other groups, such as the National Association of Broadcasters, to implement this campaign.

PROPOSAL TO DEVELOP MODEL SECONDARY SCHOOL COURSE UNITS FOR THE TEACHING OF FAMILY FINANCIAL MANAGEMENT AND LONG-TERM PLANNING

The Problem

Many Americans are not aware of the importance of early financial planning for health care costs, retirement, and other economic needs likely to arise in later life. There is a widespread misperception that when an individual reaches retirement age, the government, through Medicare and social security, will provide all necessary health care and income support. As a result, many Americans often do not learn about the limitations in the benefits provided by these two programs until retirement, at which point it is too late to undertake a program of savings and investment crucial to support during retirement years.

In particular, young people who graduate high school and enter college or employment tend to view their retirement years as a time so distant that they need not provide for it. Young people also see themselves as healthy, and, during their early working years, often do not appreciate the need to budget for, or insure against, predictable health care expenditures. For example, in hearings around the country, the Council heard numerous State and local employees express their regret at having declined Federal social security coverage when, in their twenties, they were asked to plan their retirement pensions.

Young people need to be taught the importance of budgeting and planning for these expenses if every American is to take responsibility to meet them adequately.

The Proposal

Model Secondary School Course Units and Materials

The Secretary of Health and Human Services, in conjunction with the Secretary of Education, would develop and disseminate to States model secondary school course units and materials for teaching family financial management and long-term planning to meet major expenses, such as those associated with:

- health care, including major medical expenses;
- education;
- purchase of a home;
- child care;
- unemployment; and
- retirement.

Course units would include elements on credit card and checking account management, the availability of pertinent Federal and state programs (e.g., Federal student loan guaranties, State unemployment insurance benefits), and tax planning (e.g., IRA and Keogh plans).

The course units would also contrast the American social welfare system with those of other countries in order to provide the student with some historical perspective.

Suggested Course Unit Content

The course units could be designed to cover the following topics:

- **Retirement planning.** A unit on retirement planning could cover these topics:

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- *Determination of income needs.* How to determine the amount of income an individual would require to support his or her needs at retirement; how to plan savings or other investments to meet those needs; and how to plan for a retirement dependent upon multiple income sources, such as social security, pension plans, and savings.
 - *Social Security.* The purpose of Social Security as a supplement to other retirement savings; the eligibility rules for social security; and the level of benefits an individual would expect to receive under social security based on the number of years worked and income levels.
 - *Pension plans.* The types of pension plans offered by private employers; how to evaluate plans and compute benefits; and the impact of changing jobs during one's lifetime on the vesting of retirement plans.
 - *Savings.* The types of other private financial products, such as IRAs and annuities, available to individuals to enable them to meet their retirement income needs and how to evaluate and make decisions about these types of products.
 - **Health care expense planning.** A unit on planning for health care expenses could cover these topics:
 - *Health expense education.* The types of health care expenditures that an individual may incur during his or her lifetime, including expenses for primary and preventive care, hospital care, physician care, long-term care, prenatal and well-baby care, prescription drugs, and other types of care.
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- *Availability and role of health insurance.* The types of health insurance available in the United States, including employer-based insurance, individually purchased coverage, and coverage from groups such as unions and professional associations; the types of costs that will be incurred by the individual, such as premiums, coinsurance, copayments, deductibles, and out-of-pocket costs for noncovered items; options for different types of plans, such as indemnity plans, HMOs, PPOs, and other types of managed care plans; long-term care insurance and medigap plans; the importance of being covered by health insurance throughout one's lifetime, especially for unexpected catastrophic expenses; and how to choose the proper health insurance plan based on one's age, income, health status, and family status.
 - *Medicare and Medicaid.* The purpose of the Medicare and Medicaid programs; eligibility rules; types of services covered; and payment levels.
 - **Disability insurance.** A unit on the role and importance of disability insurance could cover:
 - the types of events that may cause an individual to become disabled;
 - the role of Social Security and employer-based insurance in providing income protection if an individual becomes totally or partially disabled;
 - ways to determine the income that a wage earner and his or her family will need if the wage earner becomes disabled; and
 - the appropriate type and levels of insurance that will be needed to provide disability income.
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- **Life insurance.** A unit on the role of life insurance in planning to meet the income needs of the family after the death of a wage earner could include information on the types of life insurance products offered by employers and insurance companies and skills needed to select the appropriate types of life insurance based on one's age, income, health status, and family status.
 - **Budget planning.** A unit on budget planning could teach students:
 - how to make choices about retirement planning, health expense planning, and life insurance planning in the context of their overall budgets starting when they enter the work force, and
 - how to re-evaluate their choices periodically in light of changes in their income, health status, or family status.

Appendix B:
Recommendation Specifications
Reform of Health Care Institutions

A PROPOSAL TO REDUCE THE PAPERWORK ASSOCIATED WITH HEALTH CLAIMS

Background

In order to simplify the process through which health care providers submit bills to intermediaries and to the Health Care Financing Administration, a series of meetings, known as the "UB 82" exercise, was held among representatives of HCFA, health care insurers, and intermediaries that culminated in the adoption of a single billing form. Despite agreement on this form, the UB 82 form has become merely one of a number of billing forms currently in use. Often, a payer will require the submission of the UB 82 form and a number of other forms in addition. Consequently, the savings anticipated from UB 82 have not materialized. Today, it is estimated that 20 percent of Medicare expenditures, and a significant amount for other health care expenditures, are for paperwork.

Also, the information provided by the UB 82 form is insufficient for use by HCFA in evaluating the quality of care provided. HCFA has therefore directed peer review organizations to abstract clinical information on patients using a uniform clinical data set and provide it to HCFA for all patients for which UB 82 forms have been submitted.

The Proposal

The Objective

Legislation can support a forthcoming UB 92 process in three ways:

- providing a framework to facilitate discussions;
- clearly defining their objective; and
- establishing an alternative process if the discussions were unsuccessful.

Advisory Council

The proposal would direct the Secretary to convene an Advisory Council on Health Claim Standardization to consist of 15 individuals, including representatives of the American Hospital Association, the American Medical Association, the Health Insurance Association of America, Blue Cross and Blue Shield, consumer groups, individual hospitals and health care insurers, and the Health Care Financing Administration. At least five members of the Council would be required to be currently employed as hospital administrators.

Responsibility of the Council

The proposal would direct the Council, to recommend to the Secretary, within 2 years of its appointment, a uniform health claim reimbursement form for hospital services that would include all charges—hospital and physician's services, x rays, tests, etc.—arising from an individual's hospitalization. The form would also include information needed to determine a patient's health insurance coverage and eligibility to participate

in State, Federal, or private health care programs. When promulgated by the Secretary's regulations, the form would be the sole form required by the Health Care Financing Administration or any private health care insurer in the United States as the sole basis for making payment on a claim for reimbursement for hospital inpatient services or physician's services.⁴⁵

Contents of a Uniform Reimbursement Form

The uniform reimbursement form, as recommended by the Council, shall include:

- **Uniform Clinical Data Set.** A diagnosis of the patient is based on a uniform clinical data set.⁴⁶
- **Procedures Employed.** A uniform coding of medical procedures is used to treat the patient.
- **Billing Information.** Reimbursement is requested for each procedure employed with respect to the patient, including hospital services, physician's services, x rays, tests, rehabilitative services, and so forth, as may be required to ensure that the form is comprehensive.

⁴⁵ The Omnibus Budget Reconciliation Act of 1990 (section 4112) created a Practicing Physicians Advisory Council to look into what is usually referred to as the "hassle factor" (i.e., the problems with physician billing under Medicare). In addition, the Standard Claim Form (OMB 1500), developed by HCFA in conjunction with the AMA, is now used by HCFA, Blue Shield, HIAA members, the Department of Defense, the Department of Labor, and many other public agencies and private payers as the basis for paying for physicians' services. Given recent congressional action in the area of physicians' claims under Medicare and the virtually universal acceptance of the Standard Claim Form, the proposal does not attempt to replot this ground.

⁴⁶ The Institute of Medicine has recently recommended development of an electronic medical record, with all patient information going into the record. The proposal, under development as "Quality 2000" in conjunction with congressional legislative staff, would mandate electronic data collection for hospitals by the year 2000.

Report on Computerization of Billing

The Council would also report on the computerization of health claim billing, i.e., the use of electronic means to transmit billing information from hospitals and physicians to insurers and HCFA. The report would include:

- a survey of the current state of electronic billing;
- a discussion of the impediments to more extensive use of electronic billing;
- an analysis of the probable costs of increasing the volume and standardization of such billing in relation to the savings to the health care system that could reasonably be anticipated; and
- the Council's recommendations for action that would facilitate the further extension of electronic billing in a cost-effective manner.

Administration

The Council would meet at the call of the chair. Members would be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils appointed by the Secretary under Medicare.

Development of Form by HCFA Upon Failure of the Council to Agree

If, at the end of 2 years after the Secretary has appointed the members of the Council under the proposal, the Council fails to recommend a uniform reimbursement form, the Secretary shall direct the Health Care Financing Administration to develop and promulgate such a form for the purpose within 6 months.

TECHNOLOGY ASSESSMENT AND DATA POOLING

The Problem

There is need for an adequate data base from which to develop improved methods of technology assessment and medical evaluation. In addition, hospitals and insurance companies, in consultation with the medical profession, need to compare and pool data. Currently no institutional machinery exists to ensure that this data base will be assembled, and the current state of antitrust enforcement would deter private organizations from pooling such data.

The Proposal

Advisory Group on Technology Assessment Data

The Council recommends that the Secretary of Health and Human Services establish an Advisory Group on Technology Assessment Data.

Membership. The Group shall consist of representatives from the Agency for Health Care Policy and Research, the Health Care Financing Administration, the Public Health Service, the Department of Defense, the Veterans' Administration, the Institute of Medicine of the National Academy of Science, and private members representing consumer groups, medical device manufacturers, health care insurers, health care providers, employers, and recognized experts in health policy research.

Mission. In order to promote assessment of technology through the use of a wider base of information that can be linked together, the Group shall

develop standards to be used in the collection and maintenance of such information. The Group shall also develop uniform definitions of information to be collected and used in describing a patient's clinical and functional status, common reporting formats for such information, and standards to ensure the security, accuracy, and appropriate maintenance of such information.

Report. Within 1 year after it is established, the Group shall report to the Secretary on the feasibility of linking such assessment-related information of the Department of Health and Human Services with such information collected or maintained by other Federal departments and agencies and by private organizations.

Staffing. The Agency for Health Care Policy and Research shall provide the Group with necessary technical, administrative, and clerical staff and with other facilities.

Amendment of the Antitrust Laws

The Council recommends that the Attorney General and the Secretary of Health and Human Services jointly develop proposals for legislation to amend the antitrust laws to permit hospitals and insurance companies, in consultation with the medical profession, to compare and pool data for the purpose of developing improved methods of technology assessment and medical evaluation.

THE MEDICAL DIRECTIVE AND PROXY ACT

The Problem

Medical advances continue to heighten the quandary of society's response to life-prolonging procedures which do not maintain the patient's quality of life. Fifty years ago, the majority of Americans died at home, receiving comfort and care in their final hours; today, 80 percent die in institutions, often tied to a spider web of tubes and wires that marshal a sophisticated technology to prolong the process of dying.

In general, individuals who retain mental competence may refuse unwanted medical care. But often persons *in extremis* are no longer competent. Then they may be subjected to medical procedures that they would have refused, that offer them no hope of recovery, and that waste their remaining resources.

Forty-one States and the District of Columbia have responded by enacting statutes enabling individuals to execute, in advance of need, a document usually called a "living will." The living will directs the withholding of extraordinary, life-prolonging care, generally after a patient has become terminally ill without prospect of real improvement or cure. But these statutes have failed to solve the problems that gave rise to them. Only 9 percent of Americans have made a living will, and even these documents do not always reach the providers of care.

In some States the living will is ineffective to govern care in the case of irreversible coma or persistent vegetative state not coupled with a terminal illness. In all cases, its language is vague ("no reasonable expectation of recovery from extreme physical or mental disability," "artificial means and heroic measures," and so forth) and open to differing interpretations as to the

conditions covered and the interventions that the patient, if competent, would accept.

The "durable" power of attorney, i.e., a power of attorney that comes into effect, or remains effective, when the individual who has executed it becomes incompetent, can serve as an alternative or supplement to the living will. However, although all States permit the use of the durable power, in many States it is unclear whether it may be used to designate a proxy to make health care decisions. Moreover, many individuals may be reluctant to vest such an unconstrained authority in the hands of another. Finally, even if an individual chooses to do so, the designated proxy may be uncertain as to how to exercise the power, particularly one executed many years before the event.

The Proposal, in General

Legislation, to be cited as the "Medical Directive and Proxy Act," would be proposed to require that a Registry be established within the Department of Health and Human Services. The Registry would provide a "Medical Directive and Proxy Designation" form⁴⁷ to all physicians who treat Medicare patients, and to any other physician who requests the form. The Registry would also inform each individual eligible for Medicare of the availability of the form at the office of the individual's physician and would encourage the individual to ask the physician to interpret the form and explain how it is to be executed. No physician would be required to assist an individual in interpreting or executing a form; however, if the physician accepts Medicare patients, the physician would be required to refer the individual to some other physician for the requested guidance.

⁴⁷ The form contemplated would be based on the form developed by Linda L. Emanuel, M.D., Ph.D., and Ezekiel J. Emanuel, M.D., Ph.D., and described in their article, "The Medical Directive, A New Comprehensive Advance Care Document," 261 *JAMA* 3288, June 9, 1989.

An individual who chooses to execute the form would file with the Registry the form signed by the individual and the individual's designated proxy.⁴⁸

The form would accomplish two purposes:

- It would allow an individual to designate the acceptability of specified life-prolonging medical procedures in the event of any of a small number of medical situations in which the patient has little or no competence to act for himself.
- It would appoint a proxy with the authority to make decisions regarding the cessation of life-sustaining treatments upon the individual's incompetence.

The proxy would be bound by the patient's choices evidenced in the medical directive portion of the form unless the patient specifies otherwise and would in any event be guided by that portion in making decisions not covered by it.

At the request of the patient or the patient's proxy, the Registry would supply a copy of the executed form to any physician of the patient or an appropriate licensed health care provider.

The bill would contain provisions, described below, to ensure the effectiveness of the form and to enable the individual who has executed it to revise or revoke it (if competent). From time to time, as new life-sustaining treatments become available, the Registry would promulgate amended forms, provide them to physicians, and advise registrants of their availability.

⁴⁸ In the case of minors eligible for Medicare by reason of disability, the parent or guardian would in any event be required to make the decision as to what care to authorize at the time that care is required. However, the proposal would allow the minor (through the minor's parent or guardian) to execute a Medical Directive and Proxy Designation form so as to take advantage of the provisions of the proposed law that override State limitations discussed earlier.

The Proposal's Scope

Federal Preemption of State Law With Respect to Medicare Beneficiaries

Living will legislation has been the exclusive domain of the States. Proposals for Federal involvement have generally confined themselves to suggestions for model State living will statutes, or for Federal laws limited to requiring Medicare and Medicaid beneficiaries to be informed of their rights to execute advance medical directives under State law.⁴⁹ The instant proposal would encroach on that dominance by overriding State law in a few marginal situations: most notably in allowing an individual, regardless of the law of the State in which health care is received, to direct the withdrawal of that care (including the withholding of artificial nutrition and hydration) in the event of irreversible coma or persistent vegetative state.

The provisions of the instant proposal that override State law would apply only to Medicare beneficiaries. The health care of a Medicare beneficiary is largely paid for by the Federal Government. There is therefore a strong Federal interest in the medical care of Medicare beneficiaries: what care is to be provided and when it is to be provided. Preemption of State law, even when quite limited, is most defensible on constitutional and policy grounds when necessary to accomplish a legitimate Federal objective: in this case,

⁴⁹ This was the approach taken in 1982 by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. See, also, the "Patient Self Determination Act of 1989," S. 1766, 101st Cong. (Danforth); "An Act To Provide for the Creation of a Durable Power of Attorney for Health Care," proposed as a model State law by the American Medical Association in October 1986; and sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, Public Law 101-508, which amended the Social Security Act to require health care providers to inform Medicare and Medicaid beneficiaries of their rights under State law to accept or refuse medical care, including the right to make "an advance directive" concerning that care.

ensuring the economical use of Medicare trust funds in providing care to those beneficiaries.

Application to Other Individuals

The Medicare population, consisting of persons who are aged or seriously disabled, is the population group that appears to have the greatest need for an effective means of governing medical care in the event of mental incompetence. A proposal is most credible, generally speaking, when it evolves from a felt need. Nevertheless, although the proposal's State law override provisions would apply only to Medicare beneficiaries, any individual would be allowed to execute a Medical Directive and Proxy Designation and file it with the Registry.

The Proposal, Major Features

Establishment of Registry

The Secretary of Health and Human Services would be directed to establish a Registry for the purpose of developing and disseminating a Medical Directive and Proxy Designation form, registering an official copy of each executed form, and providing certified copies of the form to appropriate physicians and other licensed health care providers.

Location in DHHS

The Registry would be located, organizationally, within an agency of the Department of Health and Human Services designated by the Secretary.

Development of Form. The Registry would develop, within 4 months after its establishment and after consultation with interested individuals and

organizations, a Medical Directive and Proxy Designation form that meets the requirements described below.

Notification of Physicians and Medicare Eligibles. Upon completion of the form, the Registry would take the necessary steps:

- to inform primary care physicians of the availability of the form and who may execute it,
- to inform all Medicare eligibles of the nature of the form and how it may be executed, and
- to conduct outreach activities through public and private organizations, agencies, and institutions to inform the public about the form.

Thereafter, the Registry would inform individuals of the form and how it may be executed upon their first becoming eligible for Medicare.

Maintenance and Release of Records. The Registry would establish a procedure for recording the existence of, and retaining, all executed forms, revised forms, and revocations of executed forms. The procedure for revising or revoking an executed form is described below.

Medical Directive and Proxy Designation

Terms. The Medical Directive and Proxy Designation (the "MD&PD") would be in two parts: a medical directive and a designation of proxy.⁵⁰

⁵⁰ The form described is essentially the form proposed by the Drs. Emmanuel, op. cit. note 51.

Medical Directive. The medical directive portion would specify the procedures covered, paradigmatic cases in which a physician might reasonably direct the use of one or more of such procedures, and the patient's wishes with respect to those procedures in the context of the paradigmatic cases.

Procedures Covered. The Secretary's regulation would specify the procedures covered and would be amended from time to time (with appropriate notice to registrants) to reflect new procedures. Initially it would be expected that the procedures covered would include:

- cardiopulmonary resuscitation,
- mechanical breathing,
- artificial nutrition and hydration,
- major surgery,
- minor surgery,
- kidney dialysis,
- chemotherapy,
- invasive diagnostic tests,
- simple diagnostic tests,
- transfusion of blood or blood products,
- use of antibiotics, and
- pain medication that may dull consciousness or indirectly shorten life.

Paradigmatic Cases. The form would contain a small number of cases with respect to which the individual would express his wishes (as described in the next paragraph) as to the procedures listed in the preceding paragraph. These cases would, at least, include the following:

- A coma or persistent vegetative state, where there is no known hope of regaining consciousness;

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- Brain damage or disease that cannot be reversed and which makes the individual unable to recognize people or speak intelligibly, with little or no likelihood of regaining significant higher functions;
 - Brain damage, as previously described, coupled with a terminal illness.

Expression of Individual's Wishes. The form would contain a small number of multiple choices through which the individual would express his wishes, e.g., "I want the procedure," "I do not want the procedure," "I will leave the judgment to my proxy," "I want a trial of the procedure, but suspension of treatment if no clear improvement."

Proxy Designation.

Who May Serve. The proxy decisionmaker may not be a person, or an employee of a person, who, at the time of making a health care decision under the designation, is responsible for providing health care to the individual executing the proxy or is an employee of a company that has issued to that individual a policy of life or health insurance.

Withdrawal of Proxy. An individual may change the designation of a proxy in such manner as the Secretary's regulations may provide, except that any such change must be in writing unless it is determined that the individual, although competent, is physically unable to execute a written document.

Explanation of Revision and Revocation. The form would contain a clear explanation of:

- the manner in which an individual may revise or revoke the form (as described below) and

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- the effect of an individual's choice to allow, or not allow, the designated proxy to override the choices expressed in the Medical Directive portion of the MD&PD.

Execution of Form.

Signature of Individual. The individual executing the form would sign it and provide his home and business addresses.

Designated Proxy to Co-Sign. The designated proxy would co-sign the form and provide his home or business address.

Effectiveness. Notwithstanding the law of any State to the contrary, a properly executed MD&PD would be effective at least with respect to the paradigmatic conditions described therein. Nevertheless, the MD&PD could not authorize the administration of any medication for the purpose of shortening the life of the subject or the refusal to provide normal feeding or hydration.

Filing with the Registry

Who May File. Any person may file with the Registry a properly executed MD&PD.

Copies. If the MD&PD is filed by any person other than the individual who has executed it, the person filing it would be instructed by the form to attest on it that a copy has been provided to such individual and to the co-signers.

Notification. The Registry would make a permanent record of the receipt of a properly executed MD&PD and would send a notice to the signer and co-signers concerning the Registry's receipt of it. The Registry would subsequently make the form available to a physician or other licensed health

care provider upon receiving evidence that the physician or provider is engaged in providing care to the signer.

Payment of Fee. The Registry may establish a fee to defray its administrative costs. The Registry would refuse to file an MD&PD unless accompanied by the prescribed fee.

Revision and Revocation. An individual for whom an MD&PD is on file would be enabled to revise or revoke it in accordance with the Secretary's regulations, subject to the following restrictions:

Writing Required. A revision or revocation would be required to be signed by the individual or accompanied by an attestation of two witnesses that the individual, although mentally competent, is physically unable to sign the document.

Witnesses. If the individual is capable of signing the document, the signature must be attested to by a notary public.

Mental Incompetence. Notwithstanding the law of any State to the contrary, an MD&PD could not be revised or revoked on behalf of a mentally incompetent individual by a guardian appointed to act in his behalf or by any other person.

Participation of Physician

Payment of Fee. If a physician agrees to interpret the MD&PD to a patient, or assist a patient to execute it, Medicare will reimburse the physician for an office visit.

Referral of Patient. If a physician declines to interpret the MD&PD to a patient, or assist a patient to execute it, the physician, if he accepts Medicare

patients, will be required to refer the patient to another physician who will provide the requested guidance.

Immunity of Physician and Other Licensed Health Care Providers. A physician or other licensed health care provider would be immune from any liability that might attach to advice given in connection with the form or the physician's failure to comply with any provision.

Not a Condition for Providing Services. No physician or other licensed health care provider would be permitted to condition the provision of treatment on the existence or execution of an MD&PD.

Effect on Policies of Life Insurance

No policy of life insurance would be permitted to deem compliance with an MD&PD a suicide under the policy. The bill would declare any such provision invalid.

State Participation

As indicated above, the Registry would be available for all citizens who choose to file a Medical Directive and Proxy Designation form and pay the required fee. However, at the discretion of the Secretary, a State could enter into an arrangement with the Registry under which the State would pay the Registry fees for its citizens, reimburse the Registry for special arrangements, e.g., notifying physicians and citizens of the State of the availability of the form, making a statewide distribution of the form to physicians, and providing the State with computer access to the Registry data base (subject to appropriate safeguards of individual privacy).

HOSPITAL MERGERS AND JOINT VENTURES

The Problem

Since the adoption of DRGs in the early 1980s, hospital admissions and occupancy rates have declined, particularly in small communities. It has become very costly for communities with two or more hospitals, each with low occupancy rates, to maintain multiple hospitals. However, communities develop a strong sense of identity with their local hospitals and are reluctant to see one facility close in favor of another. Many local communities have proposed mergers of two hospitals in order to maintain their sense of community identity while pooling services, personnel, and expensive equipment. However, current antitrust laws prevent such mergers because of the anticompetitive impact. Alternatively, other communities have proposed joint ventures using two hospital facilities for a hospital and a different purpose, such as a nursing home, but their proposals have been inhibited because of antitrust laws as well as Medicare fraud and abuse considerations.

The Proposals

Hospital Mergers

The Council would propose that the Attorney General develop proposals for legislation to amend the antitrust laws to permit mergers of two hospitals in the same community in limited cases. The proposed legislation should include criteria relating to the length of time each hospital has served the community, the occupancy rates and relative financial condition of each hospital, and the willingness of each hospital to engage in the merger.

Joint Ventures

The Council would propose that the Attorney General and the Secretary of Health and Human Services jointly develop proposals for legislation to amend the antitrust laws to permit two hospitals in the same community, in a limited case, to enter into a joint venture for the provision of hospital services at one facility and health-related services (such as long-term care or outpatient care) at the other hospital facility. The proposed legislation should include criteria relating to the length of time each hospital has served the community, the occupancy rates and relative financial condition of each hospital, the types of services to be provided by the joint venture, and whether the new services to be provided meet an unmet need in the community.

FACILITATING THE DISSEMINATION AND USE BY PHYSICIANS OF EFFECTIVENESS RESEARCH AND MEDICAL PRACTICE GUIDELINES

The Problem

The Department of Health and Human Services, through the Agency for Health Care Policy and Research, is supporting research on the appropriateness and effectiveness of alternative strategies for the prevention, diagnosis, treatment, and management of a variety of acute and chronic conditions and along with other entities is developing medical practice guidelines for use by health care providers. Practice parameters, the development of which by the medical profession is strongly advocated by the American Medical Association, will encourage and enhance the delivery of the most appropriate care to each patient. They would supplement the physician's judgment in reducing unnecessary and inappropriate variation in the use of health care services and procedures.

While there is a wealth of scientific information available to physicians to assist them in making professional judgments, mechanisms need to be developed to train physicians, during their undergraduate educations, to have the substantive background and skill level to enable them to use, and be comfortable in using, effectiveness research results and medical practice guidelines as an integral and regular part of their practice. Also, since there are, and will continue to be, more information and guidelines available to assist physicians in residency and practice, continuing medical education courses and new technologies need to be developed to enable residents and practicing physicians to use this information and apply it in the cases of specific patients.

In the educational courses proposed below, emphasis would be placed on assisting the medical profession to reach consensus on different sets of guidelines and on methods of dissemination of the information.

The Proposals

Enhancement of Medical Education

The Council recommends three proposals to facilitate the dissemination to, and use by, students, residents, and physicians of effectiveness research and medical practice guidelines. One proposal is directed at undergraduate medical education; the second is directed at continuing education for physicians; and the third is directed at new technologies to assist graduate medical education and physician practice.

Undergraduate Medical Education Course in Subjects Relating to Effectiveness Research.

Model Curriculum. The Secretary of HHS, through the Agency for Health Policy and Research, would develop a model curriculum and materials for a course to be given to fourth-year medical students. The course would include training in epidemiology, biostatistics, research methodology, and technology. The purpose of the course would be to give students a thorough grounding in subjects which are the foundation of effectiveness research and the development of practice guidelines in order that, as practicing physicians, they would have the skills to use the scientific information available to them and appreciate the value of guidelines as a tool for patient diagnosis, treatment, and management.

Cooperation with Academic Institutions and Professional Societies. The Secretary would work with medical schools, medical societies, and professional associations in developing the model curriculum and to ensure

that the curricula and materials are incorporated by medical schools around the country.

Continuing Medical Education.

Model Curriculum. The Secretary of HHS, through the Agency for Health Policy and Research, would develop a model curriculum and materials for a continuing medical education course for practicing physicians. The course would include training in epidemiology, biostatistics, research methodology, and technology. The purpose of the course would be to give practicing physicians a thorough grounding in subjects which are the foundation of effectiveness research and the development of practice guidelines and to provide them with the skills needed to use the scientific information available to them and to appreciate the value of guidelines as a tool for patient diagnosis, treatment, and management.

Cooperation with Academic Institutions and Professional Societies. The Secretary would work with hospitals, medical schools, medical societies, and professional associations in developing the model continuing medical education course and to ensure that the curricula and materials are made widely available around the country.

Technologies to Train Residents and Assist Practicing Physicians.

Development of Computer-Assisted Models. The Council would recommend that a grant program be established at HHS to support the development of computer-assisted models to enable residents and practicing physicians to have access to the vast range of textbooks, literature, effectiveness research results, and practice guidelines developed by public and private research institutions, medical societies, and the public. The models would contain teaching units that would help physicians determine the most efficient and effective methods of diagnosis, treatment, and management of patients

presenting different symptoms and would help to minimize unnecessary tests, treatments, and associated costs.

Use in Residency Programs. DHHS would work with residency programs across the United States to encourage the incorporation of computer-assisted models in residency training. The purpose of this would be twofold: to expand the information and practice guideline base available to residents during their training in addition to that provided by residency program faculty and to encourage graduates of residency programs to use these computer-assisted models when they enter practice.

Study and Evaluation

The Secretary of Health and Human Services would commission a broad-ranging, long-term study of medical education in order to:

- develop and recommend additional means of enhancing medical education so as to improve the ability of physicians to incorporate information on the outcome of medical procedures into their own treatment modalities and
- undertake longitudinal studies to evaluate the effectiveness of the training proposed above in improving the quality of medical care provided by physicians who have received it.

MERGING MEDICARE PARTS A AND B

The Issue

When Medicare was established in 1965, the hospital played the critical role in the provision of health care services. Most procedures and tests were performed in the hospital, and patients recuperated there until they were ready to be sent home. Because of the central role of the hospital in 1965, Medicare Part A was established as a hospital insurance program. Part B was established as a voluntary supplemental insurance program, and each part had its own funding sources.

Several factors have occurred since 1965 which reduce the need for the separation of the two parts of the program. Many types of procedures once provided in the hospital are now provided in outpatient settings, and many services incident to a hospital stay (such as preadmission testing) are now performed on an outpatient basis.

Furthermore, the percentage of Medicare expenses for Part A has been steadily decreasing, while expenses for Part B have been increasing. The separation between the Part A trust fund and the premiums and general revenues for Part B inhibits evaluation of total program expenditures and goals.

The distinction between Parts A and B is becoming less important to consumers of services. Also, HCFA is increasing its capacity for integrating Part A and B files so that it can study overall use of health care services. It is time to consider whether administrative efficiencies, both for the program and consumers, can be achieved by the merging of Parts A and B.

The Proposal

The Advisory Council recommends that the Medicare law be amended to combine the administration of Parts A and B into one program. Eligibility and financing would not change. The three separate funding sources—payroll taxes, general revenues, and premiums for Part B would remain, and a method would be developed by HCFA to maintain the integrity of the relative share of program costs for purposes of determining the part B premium.

Combining Parts A and B has several advantages. The Medicare program would be viewed as a single unified program with common administrative and management goals. The impact of program expenditures could be evaluated and analyzed in terms of their total impact on the economy, and a unified portrayal of the long-range obligations of the program could be accomplished. Administrative efficiencies would result in savings for the program and easier interaction with the program for beneficiaries.

Appendix C: Cost Estimates

Estimates of
Savings and Costs
To the Federal Government
of Selected Health Care System
Reform Proposals and
Demonstration Projects
December 17, 1991

Prepared By:
Donald N. Muse, Ph.D.
President
Policy Research Group
1317 F Street, NW, Suite 400
Washington, DC 20005
202-737-0100

Preface

This paper contains estimates of twenty six proposals for reform of the health care system and demonstrations made by the Advisory Council on Social Security. The estimates are organized into:

- A statement of the proposal,
- The basis of the estimate and key assumptions, and
- The estimate itself.

Unless otherwise noted, the estimates are calibrated to the Congressional Budget Office (CBO) August 1991 baseline.

It is important to note that the proposals have been estimated as a package. Removal or modification of a proposal can cause the cost or savings from other proposals to increase or decrease. For example, eliminating the infant mortality proposal would increase the cost of the school-based clinic proposal.

Coordination of Estimates and Council Proposals

The descriptions of the Advisory Council's proposals are not precisely the same as those contained in the final report of the Council printed elsewhere. The press of printing and other deadlines prevented precise coordination of detailed proposal descriptions between this report and the main Council report. However, the estimates contained in this report are, to the best information available to the author, essentially the same from a cost estimator's point of view, as those contained in the Council's final report.

Acknowledgements

The author is indebted to the numerous persons who provided information used in the preparation of the estimates and the assistance of Advisory Council staff. Without their assistance and the editorial and secretarial support of Ms. Elizabeth Salomon, this report would not have been possible.

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SUMMARY TABLE OF COSTS AND SAVINGS ASSOCIATED WITH REFORM AND DEMONSTRATION PROPOSALS

Numbers in millions of Dollars By Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>TOTAL</u>
PROPOSALS TO INCREASE THE ROLE OF SCHOOLS IN THE HEALTH CARE SYSTEM				
1. A PROPOSAL TO ASSIST STATE DEPARTMENT OF HEALTH TO ESTABLISH SCHOOL-BASED HEALTH CLINICS TO PROVIDE PRIMARY HEALTH CARE	681	1423	1453	3557
2. A PROPOSAL TO ASSIST THE STATES TO PROVIDE SCHOOL-BASED MAJOR MEDICAL INSURANCE	50	500	500	1050
3. A PROPOSAL TO DEVELOP MODEL SECONDARY-SCHOOL COURSE UNITS FOR THE TEACHING OF FAMILY FINANCIAL MANAGEMENT AND LONG-TERM PLANNING	1.5	1.5	.5	3.5
4. A PROPOSAL TO PROVIDE DRUG AND ALCOHOL ABUSE PREVENTION, EDUCATION, AND TREATMENT FOR PRESCHOOL CHILDREN	0	0	0	0
PROPOSALS TO REFORM THE HEALTH CARE SYSTEM				
5. THE MEDICAL DIRECTIVE AND PROXY ACT	0	0	0	0
6. RESEARCH TO FOSTER INDEPENDENT LIVING	5	109	110	224
7. FACILITATING THE DISSEMINATION AND USE BY PHYSICIANS OF EFFECTIVENESS RESEARCH AND MEDICAL PRACTICE GUIDELINES	5	3	2	10

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>TOTAL</u>
8. ALTERNATIVE PROCEDURE TO ADJUDICATE MALPRACTICE CLAIMS	10	35	-330	-285
9. INCREASING ACCESS TO PRIMARY CARE	210	400	390	1000
10. A PROPOSAL TO REDUCE INFANT MORTALITY	124	370	470	964
11. A PROPOSAL TO PROMOTE EMPLOYER-BASED HEALTH INSURANCE	0	0	0	0
12. HEALTH INSURANCE FOR THE SELF-EMPLOYED	0	0	0	0
C. PROPOSALS TO INCREASE THE EFFICIENCY OF MEDICARE				
13. A PROPOSAL TO REDUCE THE PAPERWORK ASSOCIATED WITH HEALTH CLAIMS	1	1	50	52
14. HOSPITAL MERGERS AND JOINT VENTURES	0	0	0	0
15. A PROPOSAL TO ESTABLISH CENTERS OF EXCELLENCE	0	-5	-10	-15
16. A PROPOSAL TO CONTAIN MEDICARE COSTS THROUGH USE OF SELECTIVE CONTRACTING ¹	0	-60	-170	-230
17. MERGING MEDICARE PARTS A AND B	0	0	0	0
D. TASK FORCE AND OTHER INITIATIVES				
18. TASK FORCE ON INVESTMENT IN HUMAN RESOURCES	0	0	0	0
19. PROMOTING HEALTHY LIFESTYLES THROUGH THE PRESIDENT'S COUNCIL ON PHYSICAL FITNESS	.2	.2	.3	.7

¹ This is a conservative estimate. Depending on Secretarial actions, this proposal could save \$640 million over the three years. See write up for detail.

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>TOTAL</u>
20. POOLING OF DATA AND TECHNOLOGY ASSESSMENT	0	0	0	0
21. ESTABLISH PRESIDENTS COUNCIL ON FITNESS FOR THE SECOND FIFTY YEARS	2	5	5	12
22. DEVELOP INFORMATION ON MEDICAL TREATMENT OUTCOMES	0	0	0	0
23. PUBLIC EDUCATION CAMPAIGN ON PREVENTION	10	20	20	50
SUBTOTAL REFORMS ²	1100	2803	2491	6393
E. MEDICAID DEMONSTRATIONS				
IMPROVING ACCESS TO MEDICAID SERVICES	203	403	403	1009
OUTREACH DEMONSTRATIONS	203	403	403	1009
INCREASING MEDICAID COVERAGE OF UNINSURED	103	203	203	509
SUBTOTAL MEDICAID DEMONSTRATIONS	509	1009	1009	2527
F. PROTOTYPE COMPREHENSIVE REFORM DEMONSTRATIONS³				
PROTOTYPE COMPREHENSIVE DEMONSTRATIONS	500	3000	3000	6500
SUBTOTAL COMPREHENSIVE DEMONSTRATIONS	500	3000	3000	6500
GRAND TOTAL	2109	6812	6500	15421

² Totals may not add due to rounding.

³ descriptions of these demonstrations can be found in the Council's main report. The cost of these demonstrations was determined by the Council and is included here for convenience only.

PROPOSAL 1
A PROPOSAL TO ASSIST STATE DEPARTMENTS OF HEALTH
TO ESTABLISH SCHOOL-BASED HEALTH CLINICS
TO PROVIDE PRIMARY HEALTH CARE

The Proposal

It is proposed to support the establishment of a nationwide system of health clinics located primarily in or adjacent to elementary schools of the state. State departments of health would operate the clinics--directly or through arrangements with health care providers--so as to offer wider and more regular access to primary health and dental care, including routine and preventive services, for all children of elementary-school age, and for pre-schoolers.

The programs will would be paid for from multiple sources: services provided to children from Medicaid-eligible families would be paid for by Medicaid (including the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program); services provided to children eligible for such services from other programs, for example the Maternal and Child Health Block Grant or the State General Medical Assistance Program, would be paid for by those programs; and services to children from families not entitled to public or medical assistance would be paid for by those families or their insurers except for the subsidy program. Like the school lunch program, the source of payment for any child will not be evident to other participants in the program.

The program would incorporate features of managed care. A health care provider, selected under competitive bidding procedures, would deliver services to federal beneficiaries on a per capita basis, and would, at a minimum, pay for a substantial portion of a child's hospital costs.

Elements of the Proposal

A. Federal-State Program. A "School-Based Clinic Act" would be proposed as a federal formula grant program: (1) administered by the Secretary of Health and Human Services, to reimburse states, in the manner described below, for a portion of their administrative expenditures in establishing and operating health clinics in public elementary schools of the state, or in locations reasonably adjacent to public or private elementary schools within the state.

B. Services Provided. A clinic established under the Act would be required to make available to children of elementary school age, and children of pre-school age, the following services:

1. Preventive health care services, including immunizations, periodic well-child visits, and hearing and vision testing.
2. Primary health care.
3. Dental care.

C. Eligibility for Services. Any child of pre-school or elementary school age would be eligible to receive services at a clinic.

D. Provision of Services. Services may be provided by health care practitioners employed by the state Department of Health (the "Department"), or engaged under contract (but see G, below). Insofar as practicable, considering the location of the clinic and the patient population, the Department would endeavor to provide a physician who would be on duty at the clinic for all or part of each school day or alternate day, depending upon the number of children to be serviced.

E. Payment for Services.

1. Medicaid Eligibles. In the case of services to a child from a Medicaid-eligible family, Medicaid (including EPSDT) would pay for the services.

2. Others. In the case of services to other children, payment may be on such basis as the state (in the case of a state-operated school) or local educational agency may provide. A participant in the program would not be aware of the source of payment for other participants.

F. Location of Clinic. It is the objective of the program to encourage the establishment of a school-based clinic easily accessible to every child of elementary school age.

1. Public Elementary Schools. Insofar as practicable, the Department would be required to establish a clinic on-site in existing public elementary school space.

2. Other Locations. Where existing public elementary school space is inadequate, and it is necessary to establish a clinic to make health care services readily accessible to students at that school, the Department may establish the clinic in commercial or other space.

3. Private School. Clinics must be established to provide services to children attending private elementary schools.

G. Management of Clinic. The Department would operate each clinic directly or through arrangements with providers. However, where considerations of economy and efficiency dictate, the Department could contract for outside management services. In such case the Department would be required to follow these procedures:

1. Quality Assurance. Each provider would be required, as a condition of the contract with the Department, to undertake to perform services for contract beneficiaries of the same quantity and quality provided to the provider's other patients. A failure to perform would be a breach of contract that would make the provider liable for appropriate liquidated damages established under the contract (subject to the Secretary's regulations), and termination of the contract.

H. Administration

1. Matching Rate. The federal matching rate under the program would be 75 percent and 25 percent state. Funds would be allocated among the states on the basis of elementary-school-aged population in each state, as estimated in advance of each program year by the Bureau of the Census. In addition, the federal government would provide a \$600 million annual subsidy for health care in the clinics extended to non-medicaid eligibles subject to sliding scale fee payments. Funds would be allocated among the states on the basis of elementary-school-age population in each state, as estimated in advance of each program year by the Bureau of the Census.

2. Payment of Funds. The state would administer the funds through the Department.

3. Use of Program Funds. The Department could use program funds for the following activities:

a. Remodeling and Renovation. Remodeling or renovating existing public schools' facilities or other space so as to create a site suitable for the provision of health care services.

b. State Administrative Expenses. Department administrative expenses required to establish and inspect regularly the clinics.

c. Equipment. Purchase or rental of medical equipment reasonably necessary to provide the health care services described in III.B, above.

d. Furnishings. Necessary furnishings of the clinic, exclusive of medical equipment.

1. Use of Child Support Enforcement System. The child support enforcement provisions of the Social Security Act would be amended to clarify the authority of the courts to include, in a child support order, a requirement for the payment of the premiums to enable a child to enroll in the insurance program offered under the preceding paragraph.

Basis of Estimate and Key Assumptions

From a cost estimator's viewpoint, this proposal has two dimensions. First, there are certain overall and timing assumptions that must be made in order to price all components of the proposal. And secondly, the proposal requires several separate but interrelated estimates. It should be noted that this proposal has been estimated as part of the Advisory Council's overall package. If this proposal is implemented without the rest of the package it is more expensive than is estimated below.

Overall Assumption

First, this proposal has been priced as part of a package of proposals. Should certain other proposals be modified or deleted the costs of this proposal might increase or decrease.

A second key assumption of this estimate is that the programs would be self-funding as specified in the proposal. Specifically, this estimate assumes that once a program is established in a particular school district, the rates charged to "clients" would approximate the costs of running the program. Obviously, some school districts will "lose" money on the program and some will "make" money on the clinics.

Timing Assumptions

This estimate assumes that the Secretary of Health and Human Services(HHS) will design and implement the program in FY 1993. This is obviously an optimistic assumption. This assumption is being made so that readers may have some estimate of the costs of implementing this proposal. In reality, should this proposal become law, it would be several years before the costs and savings from such a proposal would be realized.

Individual Estimates

From a cost estimators viewpoint this proposal is five separate but interrelated estimates. Each estimate is discussed below.

Start-Up Costs

The program will require elementary schools to have (1) a room in which health services can be delivered and (2) sufficient equipment and furnishings in that room to deliver the services. However, the proposal also allows school systems to make arrangements to deliver the services in an area adjacent to the school.

Extensive discussion with school system personnel, representatives of national educational and health organizations indicated that almost all elementary schools currently have a space, usually a room, dedicated to health. This is primarily due to state and federal accreditation

requirements. In some instances, this space/room is currently being used for other purposes. As one respondent indicated, "The program might make a lot of schools have to find another place to put the xerox machine. In the small number of schools who do not have adequate space, some of the school systems in which they are located will have existing full time school maintenance personnel that can remodel or alter existing space to make it suitable for the program. Hence, the estimate assumes that less than five percent of all elementary schools will require remodeling or renovation for this new program. Based on discussions with school system personnel in charge of such projects, this should average approximately \$10,000 per school.

Discussions with a wide spectrum of school health personnel yielded a finding for the equipment and furnishings similar to that for remodeling. The vast majority of schools already have simple medical equipment necessary to deliver the care. However, most respondents indicated that the number of schools needing new equipment or to add to existing equipment would be higher than the number of school that would require remodeling. Hence, the estimate assumes that 10 percent of schools will require a complete new package of medical equipment and an additional 15 percent of school will be required to purchase at least some new equipment. Based on conversations with member companies of the Health Industry Dealers Association (HIDA), it appears that the average cost of a new equipment package is approximately \$1500. It was assumed that a school in need of a partial package would spend \$500.

It should ne noted that since the remodeling and equipment purchase will be borne by the federal government, it can be expected that school systems and states will be somewhat aggressive in claiming these funds. This estimate assumes that the federal government will succeed in identifying schools that really need such remodeling and supplies.

State Administrative Expenses

State activities will include oversight and certification of the program. Based on similar activities now being conducted by state educational agencies, it would appear that approximately one million dollars per year will be adequate for an average state (plus the District of Columbia). An additional \$2 million per year will be needed the federal level for program oversight. This means that the program will require \$53 million per year for program administration.

Increased Services to Medicaid Beneficiaries

The school clinic program will have two effects on the Medicaid program.

More Services to Existing Beneficiaries

First, it will increase services to existing Medicaid eligibles. Specifically, the clinics will identify and refer for treatment children who are currently on Medicaid for treatment of

conditions that would have previously gone untreated. It will also increase the proportion of children who actually receive EPSDT services.

It is clear that data on the magnitude of these effects is not available. However, conversations with staff of the existing Florida, New York and California school based clinic programs yielded relatively uniform opinions that approximately 15 percent of Medicaid children seen by the clinics would need at least one additional service and that the clinics would increase the current EPSDT completion rate by a 20 percent. Using current per capita's as reported to HCFA by the states this result in \$510 million in additional new services to existing Medicaid beneficiaries by 1995.

Costs of Services to New Medicaid Beneficiaries

The second effect that the school based clinic program will have on Medicaid is that it will increase the number of children with Medicaid coverage. Specifically, children and their families who are Medicaid eligible will be identified through the clinics attempt to assist families in gaining access to needed health care services. Staff in existing school based clinic programs reported this as a significant consequence of the programs activities. Based on conversations with these staff and the limited data available on the number of persons eligible but not currently enrolled on Medicaid program, it would appear that approximately 420,000 new children and adults will be enrolled on the Medicaid program as a consequence of this proposal.

Subsidy of Nearly Poor Children

The proposal calls for a \$600 million per year appropriation to subsidize the cost of the school based program for nearly poor children not eligible for Medicaid. This amount is assumed to be 100 percent expended within the fiscal year.

Estimate

Table 1

**COSTS OF A PROPOSAL TO ASSIST STATE DEPARTMENTS OF HEALTH
TO ESTABLISH SCHOOL-BASED HEALTH CLINICS
TO PROVIDE PRIMARY HEALTH CARE
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
<u>A. Start-Up Costs</u>				
Remodeling and Renovation	75	30	0	105
Equipment and Furnishings	60	30	0	90
<u>B. Ongoing Administration</u>				
State Administrative Expenses	26	53	53	132
<u>C. Increase in Services to Medicaid Beneficiaries</u>				
Costs of Providing More Services For Existing Medicaid Beneficiaries	290	460	510	1260
Costs of Providing Services to Previously Unserved Medicaid Eligibles	130	250	290	670
<u>D. Subsidy of Nearly Poor Children</u>				
	100	600	600	1300
Total	681	1423	1453	3557

PROPOSAL 2
A PROPOSAL TO ASSIST THE STATES TO PROVIDE
SCHOOL-BASED MAJOR MEDICAL INSURANCE

THE PROPOSAL

The school system is an ideal locus for assisting parents to meet the major health needs of children through the purchase of economical group policies of major medical insurance negotiated by the school system.

A program is proposed to assist the states, through their school districts, to offer a voluntary supplemental low-cost insurance product, limited to paying the costs of major medical expenses, to all pre-school and elementary school children registered at schools of the state. The insurance would remain available until a participant attained age 22, regardless of whether the participant remained in school.

The federal government would reimburse the states, within an annual aggregate federal program cost of \$500 million, for 75 percent of their expenses in providing subsidized insurance to students from families with family incomes up to 185% of poverty level.

A state that participated in the proposed school-based clinics program would also be reimbursed, under both programs, for its annual program administrative expenses.

Basis of Estimate and Key Assumptions

The proposal calls for a \$500 million per year appropriation to subsidize the insurance of nearly poor children through age 22 who are not eligible for Medicaid. The estimate assumes that it would be 100 percent expended within the fiscal year.

Estimate

Table 2
ESTIMATE OF THE COST OF
A PROPOSAL TO ASSIST THE STATES TO PROVIDE
SCHOOL-BASED MAJOR MEDICAL INSURANCE
Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Appropriated Amounts	50	500	500	1050

PROPOSAL 3
A PROPOSAL TO DEVELOP MODEL SECONDARY-SCHOOL COURSE
UNITS FOR THE TEACHING OF FAMILY FINANCIAL
MANAGEMENT AND LONG-TERM PLANNING

The Proposal

Model Curricula and Materials

The Secretary of Health and Human Services, in conjunction with the Secretary of Education, would develop and disseminate to states model secondary-school course units and materials for teaching family financial management and long-term planning to meet major expenses, such as those associated with:

1. health care, including major medical expenses;
2. education;
3. purchase of a home;
4. child care;
5. vacations;
6. unemployment; and
7. retirement.

Course units would include elements on credit card management, checking account management, the availability of pertinent federal and state programs (e.g., federal student loan guaranties, state unemployment insurance benefits), and tax planning (e.g., IRA and Keogh plans).

The course units would also contrast the American social welfare system with those of other countries, in order to provide the student with some historical perspective.

B. Suggested Course Unit Content. The course units could be designed to cover the following topics:

1. Retirement Planning. A unit on retirement planning could cover these topics:
 - a. Determination of Income Needs. How to determine the amount of income an individual would need to support the individual's needs at retirement; how to plan savings or other investments to meet those needs and how to plan for a retirement dependent upon multiple income sources, such as social security, pension plans, and savings.

b. Social Security. The purpose of social security as a supplement to retirement savings; the eligibility rules for social security and the level of benefits an individual would expect to receive under social security based on the number of years worked and income levels.

c. Pension Plans. The types of pension plans offered by private employers; how to evaluate plans and compute benefits and the impact of changing jobs during ones lifetime on the vesting of retirement plans.

d. Savings. The types of other private financial products, such as IRAs and annuities, available to individuals to enable them to meet their retirement income needs and how to evaluate and make decisions about these types of products.

2. Health Care Expense Planning. A unit on planning for health care expenses could cover these topics:

a. Health Care Expense Education. The types of health care expenditures that an individual may incur during his or her lifetime, including expenses for primary and preventive care, hospital care, physician care, long-term care, prenatal and well-baby care, prescription drugs, and other types of care.

b. Availability and Roles of Health Insurance. The types of health insurance available in the U.S., including employer-based insurance, individually purchased coverage and coverage from groups such as teachers.

Basis of Estimate and Key Assumptions

Staff in the Office of Management and Budget within the Department of Education indicated that their Department has implemented numerous similar mandates over the last ten years. They indicated that it would cost approximately \$3 million for the development over a two-year period and then approximately \$500,000 per year for continued dissemination and updating of the materials.

Table 3

**ESTIMATE OF THE COST OF
A PROPOSAL TO DEVELOP MODEL SECONDARY SCHOOL COURSE
UNITS FOR THE TEACHING OF FAMILY FINANCIAL
MANAGEMENT AND LONG-TERM PLANNING
Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Appropriated Amounts	1.5	1.5	.5	3.5

PROPOSAL 4
**A PROPOSAL TO PROVIDE DRUG AND ALCOHOL ABUSE PREVENTION,
EDUCATION, AND TREATMENT FOR PRESCHOOL CHILDREN**

The Proposal

The Council recommends that the Surgeon General develop a program to provide prevention, education, and where appropriate, treatment, for alcohol abuse and drug abuse affecting preschool children. The program should include the development of educational materials that parents and teachers can use to teach preschool children to avoid alcohol and drug abuse, efforts to encourage producers of children's television programming to include anti-alcohol and drug abuse themes and messages in children programs, public service announcements and other public education campaigns directed specifically at children.

In addition, the Council recommends that school based health centers include programs such as Ala-Tot for preschool children in the services offered at these centers, and make referrals for alcohol and drug abuse treatment for parents of preschool and school-aged children.

Estimate and Key Assumptions

The staff necessary for these activities would be drawn from the agency staff. It would not increase federal expenditures.

Estimate

Table 4

DRUG AND ALCOHOL PREVENTION FOR PRESCHOOL CHILDREN:
Numbers in Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outlays	0	0	0	0

PROPOSAL 5
THE MEDICAL DIRECTIVE AND PROXY ACT

The Proposal

The Council recommends;

A. Establishment of Registry: The Secretary of Health and Human Services (HHS) would be directed to establish a Registry for the purpose of developing and disseminating a Medical Directive and Proxy Designation form, registering an official copy of each executed form, and providing certified copies of the form to appropriate physicians and other licensed health care providers.

B. Location in DHHS: The Registry would be located, organizationally, within HHS.

1. Development of Form: The Registry would develop, within four months after its establishment, and after consultation with interested individuals and organizations, a Medical Directive and Proxy Designation form that meets the requirements outlined elsewhere.

2. Notification of Physicians and Medicare Eligibles: Upon completion of the form, the Registry would take the necessary steps--

a. to inform primary care physicians of the availability of the form, who may execute it, and of the responsibility of the physicians toward a patient who elects to execute it; and

b. to inform all Medicare eligibles of the nature of the form, and how it may be executed.

HHS would maintain the registry and a toll free telephone line for hospital and beneficiary access to the data.

3. Payment of Fee: HHS may establish a fee to defray its administrative costs in operating the Registry. The Registry would refuse to file an MD&PD unless accompanied by the prescribed fee. Physicians who assist the elderly would be paid some fee for assisting them to be determined by the Secretary.

4. Notification of Physicians and Medicare Eligibles: Upon completion of the form, the Registry would take the necessary steps--

- a. to inform primary care physicians of the availability of the form, and who may execute it,
- b. to inform all Medicare eligibles of the nature of the form, and how it may be executed, and
- c. to conduct outreach activities through public and private organizations, agencies, and institutions, to inform the public about the form.

Thereafter, the Registry would inform individuals of the form, and how it may be executed, upon their first becoming eligible for medicare.

Basis of Estimate and Key Assumptions

This proposal would increase administrative costs of the program by (1) the development and information requirements of the bill and (2) increased ongoing operating cost for maintaining the Registry and toll free telephone line. Based on the costs of similar registries and lines operated by HHS and the Department, it would appear that the Registry would cost approximately \$2 million per year. However, since the Secretary and/or the states may recover these costs by a user fee, this provision would have no budget impact even if states expand it to cover non-Medicare citizens by charging them a user fee. It was not possible to estimate the cost of the physician fee for assisting the elderly in completion of the form since Secretarial discretion is indicated in their proposal.

This proposal would also save Medicare money through reduced lengths of stays. A shorter stay results in reduced costs for physician visits under Part B. This estimator was unable to locate any data on the number of life-sustaining situations encountered by the elderly. Hence, no estimate of savings to Part B was possible. However, the fact that this proposal would save Medicare, and to some extent other federal programs, is not questionable in the opinion of this estimator.

Estimate

Table 5

ESTIMATE OF COSTS OF MEDICAL DIRECTIVE AND PROXY ACT:

Numbers in Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Costs of Development and Administration of Registry	0	0	0	0

PROPOSAL 6

RESEARCH TO FOSTER INDEPENDENT LIVING

The Proposal

The Advisory Council recommends the establishment of a Center for Fostering Independent Living, and the funding of research oriented toward increasing independent living in America's elderly population. Specifically, the Council propose:

A. Establishment of a Center. The proposal would expand the focus of the National Institute on Aging by establishing within it a Center for Fostering Independent Living. The Director of the Center would report directly to the NIA director.

B. Mission in General. The Center would conduct and support applied research into means, social and scientific, to foster independent living among persons suffering an impairment in their ability to perform activities of daily living. Given its organizational placement, the Center would have ready access to the scientific findings of NIA as well as the other NIH institutes.

C. Functional Assessment and Evaluation of Therapies. The Center would encourage the development of improved methods of assessing the ability of impaired individuals to function in a non-institutional setting, and would undertake an evaluation of the effectiveness of existing rehabilitative therapies.

D. Alleviation of Disabling Conditions. Continuing technological advances provide a means for dealing with the disabilities often associated with aging and which frequently lead to the need for long-term care. The Center, in cooperation and consultation with the Food and Drug Administration, would support the development and availability of drugs and devices such as those to:

1. eliminate falls or reduce their effect;
2. alleviate severe hearing or vision losses;
3. treat or correct urinary incontinence;
4. aid memory so as to combat wandering behavior and other severe consequences of memory deficits, and
5. compensate for losses in mobility.

E. Living Arrangements. The Center would:

1. survey various living arrangements that would permit an individual employing them to live independently,
2. develop or support ways to optimize those living arrangements, and
3. conduct, or support the conduct of, one or more demonstrations of various living arrangements (except that no such demonstration may subsidize the living arrangements or care of any individual).

F. Guide to Independent Living. The Center would publish a Guide to Independent Living. The Guide would be widely distributed to the elderly, and would provide them with information of medical and technological developments, home- and community-based services, and improved living arrangements, pertinent to aiding them, particularly the impaired elderly, to remain within the community.

G. Technical Assistance. The Center would be authorized to provide technical assistance to states and local communities, and nonprofit organizations, in the development or implementation of improved arrangements to enable the elderly, particularly the impaired elderly, to live independently.

Basis of the Estimate and Key Assumptions

The costs of this proposal to the federal government would accrue in two ways: first, the costs of administering the program and maintaining the staff and overhead of the Center for Fostering Independent Research, and secondly, the costs of the research grants themselves. The costs of administering the program were developed by examination of the costs of operation of the current centers within the National Institute on Aging. Based on the size of existing NIA staffs relative to their grant and other responsibilities, it would appear that the new Center would need approximately 10 staff members to plan for, award, and monitor the research grants. An additional four staff members and a director would appear necessary to administer the center and carry out other functions. Based on current and projected NIA staff and administrative costs this would result in \$9 million in costs for the Center in the first full year of operation, FY 1994. The research grants could be as large or as small as available funds. The \$100 million per year level estimated below represents this estimator's opinion of the minimum level of funding suggested by the Center's mandate.

Technical Notes Concerning the Estimate

The estimate assumes that grants would be awarded in the second year of the Center's operation. Some experience of other new federal grant programs suggests that it takes several years to develop a specific research agenda and implement a new program.

Table 6
ESTIMATE OF COSTS OF RESEARCH TO
FOSTER INDEPENDENT LIVING:
Numbers in Millions of Dollars by Fiscal Year

Appropriated Amounts	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
1. Costs of Center for Fostering Independent Care Administration	5	9	10	24
2. Research Grants	0	100	100	200
Total	5	109	110	224

PROPOSAL 7
FACILITATING THE DISSEMINATION AND USE
BY PHYSICIANS OF EFFECTIVENESS RESEARCH AND
MEDICAL PRACTICE GUIDELINES

The Proposals

The Council would recommend three proposals to facilitate the dissemination to, and use by, medical students, residents, and physicians of effectiveness research and medical practice guidelines. One proposal is directed at undergraduate medical education; the second is directed at continuing education for physicians, and the third is directed at new technologies to assist graduate medical education and physician practice.

Undergraduate Medical Education Course in Subjects Relating to Effectiveness Research

Model Curricula The Secretary of HHS, through the Agency for Health Policy and Research, would develop a model curricula and materials for a course to be given to fourth-year medical students. The course would include training in epidemiology, biostatistics, research methodology, and technology. The purpose of the course would be to give students a thorough grounding in subjects which are the foundation of effectiveness research and the development of practice guidelines, in order to give them the skills as practicing physicians to use the scientific information available to them and to appreciate the value of guidelines as a tool for patient diagnosis, treatment, and management.

Cooperation with Academic Institutions and Professional Societies The Secretary would work with medical schools, medical societies, and professional associations in developing the model curricula and to ensure that the curricula and materials are incorporated by medical schools around the country.

Continuing Medical Education

Model Curricula The Secretary of HHS, through the Agency for Health Policy and Research, would develop model curricula and materials for a continuing medical education course for practicing physicians. The course would include training in epidemiology, biostatistics, research methodology, and technology. The purpose of the course would be to give practicing physicians a thorough grounding in subjects which are the foundation of effectiveness research and the development of practice guidelines, providing them with the skills needed to use the scientific information available to them and to appreciate the value of guidelines as a tool for patient diagnosis, treatment, and management.

Cooperation with Academic Institutions and Professional Societies The Secretary would work with hospitals, medical schools, medical societies, and professional associations in

developing the model continuing medical education course and to ensure that the curricula and materials are made widely available around the country.

Technologies to Train Residents and Assist Practicing Physicians

Development of Computer-Assisted Models The Council would recommend that a grant program be established at HHS to support the development of computer-assisted models, enabling residents and practicing physicians to have access to the vast range of textbooks, literature, effectiveness research results, and practice guidelines developed by public and private research institutions, medical societies, and the public. The models would contain teaching units to help physicians: determine the most efficient and effective methods of diagnosis, treatment, and management of patients presenting different symptoms, and minimize unnecessary tests, treatments, and associated costs.

Use in Residency Programs HHS would work with residency programs across the United States to encourage the incorporation of computer-assisted models in residency training. The purpose of this would be twofold: to expand the information and practice guideline base available to residents during their training, in addition to that provided by residency program faculty, and to encourage graduates of residency programs to use these computer-assisted models when they enter practice.

Basis of Estimate and Key Assumptions

The American Association of Medical Colleges (AAMC) staff and members were a major source of information for this estimate. Based on their experience, the development and dissemination of model curricula would be approximately \$2 million dollars in the first two years and approximately \$1 million per year thereafter to update and disseminate. The computer model was very difficult for them to estimate given that very few of this type of model have been developed. Contracts with two firms that develop such models in the general education area, indicated the amount of effort and dollars to produce such a model could be anywhere from "a little to a lot". Based on these conversations, this estimator selected \$3 million in the first year and \$1 million thereafter. Such models could cost more or less.

Estimate

Table 7

**COSTS OF FACILITATING THE DISSEMINATION AND USE
BY PHYSICIANS OF EFFECTIVENESS RESEARCH AND
MEDICAL PRACTICE GUIDELINES
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Appropriated Amounts				
1. Model Curricula Development	2	2	1	5
2. Computer Models	3	1	1	5
Total	5	3	2	10

PROPOSAL 8
ALTERNATIVE PROCEDURE TO ADJUDICATE
MALPRACTICE CLAIMS

The Proposal

The Advisory Council proposes a significant reform of malpractice procedures for Medicare beneficiaries. In general, the proposal removes the malpractice award process from the judiciary system into a new executive branch administrative structure. The proposal also limits the amount of the awards and attorney fees.

A. Administrative Structure. The administrative structure would be as follows:

1. Office of Malpractice Adjudication. The Act would establish, within the Department of Health and Human Services, an Office of Malpractice Adjudication (the "Office"). The Director of the Office would report to the Secretary or the Secretary's appointee.
2. Administrative Tribunal. Each malpractice claim would be heard by an administrative tribunal consisting of a presiding officer, who would be an administrative law judge meeting the qualifications for hearing examiners established by the Administrative Procedure Act, and two individuals determined by the Secretary to be expert in the field of health care or health care management. A decision of the tribunal would be by majority vote. Panels of the tribunal would be located in major population centers throughout the United States for the purpose of hearing malpractice claims against health professionals, and other health care providers, who provide health care wholly or partially paid for by a federal program.
3. Administrative Appeal. A party would be entitled to appeal a final determination of a tribunal to an administrative appeal council, a panel of which would be established within each region of the Department. The panel would be required to accept the tribunal's findings of fact, unless arbitrary, capricious, or unreasonable. The appeals council would be obligated to hear and decide the appeal within four months after the tribunal's decision.
4. Appeal to United States Court of Appeal. The judgment of the appeals council could be appealed, on matters of law, to the United States Court of Appeal for the circuit within which the malpractice claim arose. The court would be without jurisdiction to reexamine findings of fact affirmed on administrative appeal, although it could remand the case to the agency with instructions to find additional facts. The court would be required to affirm the judgment of the appeals council unless it were found to be arbitrary, capricious, or unreasonable.

B. Judgments. Judgements rendered by the system would be structured in the following ways:

1. Economic Loss. A judgment for the claimant under the Act would be for the claimant's past, present, and future economic loss resulting from physical damage attributable to malpractice.

2. Collateral Source Reduction.

a. Amounts Not Deriving from a Federal Program. A judgment would be reduced by any insurance or other amount to which the claimant became entitled in compensation of illness or injury resulting from the claimed malpractice (except amounts deriving from a federal program).

b. Amounts Deriving from a Federal Program. A judgment would be reduced by one-half of any amount deriving from a federal program. In such case a supplementary judgment would be issued in favor of the United States for the balance of the payments. In the case of Medicare, this latter amount would, upon payment, be credited to the pertinent Medicare trust fund. In the case of a federal direct care program, the amount would be deposited in the general fund of the treasury. In the case of a federally assisted state program, the money would be divided, as appropriate, between the general fund of the treasury and the state.

3. Noneconomic Damages. Noneconomic damages, such as pain and suffering, would be limited to \$2 million. Derivative damages, such as a wife's claim for pain and suffering, would be abolished.

4. Attorney's Fees. A judgement for the claimant would include an amount for attorney's fees, in accordance with a schedule established by regulator within a ceiling set by the statute. The proposed ceiling is 25 percent of the first \$1 million, 15 percent of the next \$200,000, and 10 percent of the remainder.

5. Costs of Proceeding. The tribunal could, in its discretion, assess either or all parties an amount, established by regulation and payable to the general fund of the Treasury, equivalent to all or part of the administrative costs of the proceeding.

6. Comparative Negligence. An award for the claimant would be reduced in proportion to the degree to which the tribunal found that the claimant's negligence had contributed to the injury.

7. Liability of Parties Defendant. If there are two or more parties defendant, they would not be jointly liable. A judgment against a party defendant would be limited to that party's proportionate share of the injury caused.

8. Award for Future Economic Loss. An award for future economic loss would not require the payment within a calendar year of an amount that exceeded the loss anticipated for that year; but such award would not be subject to future adjustment.

9. Derivative Rights. No award could be made to any party based upon injury caused by malpractice in the medical treatment of some other person.

C. Exclusions. The Office would be without the power to adjudicate a malpractice claim alleging:

1. wrongful death, or
2. willful injury.

D. Exclusivity of Remedy. Except as otherwise provided by this Act, no court of any state, or of the United States, would have jurisdiction to adjudicate any claim arising from, or alleging, malpractice, if that claim were cognizable under this Act. In other words, the Act would be the exclusive avenue available to federal beneficiaries for pressing malpractice claims.

Model State Malpractice Act

Like the proposed federal act, the model state act would seek to restrain further growth in the cost of malpractice insurance, which has both inflated the cost of medical care and reduced the availability of health care in some medical specialties.

The proposal adopts an administrative alternative to the present system of tort liability. Administrative alternatives, either as a supplement to, or replacement of, the existing system have been proposed by the Health Care Provider Liability Reform bill, based on the 1987 report of the Department of Health and Human Services' Task Force on Medical Liability and Malpractice, the Ensuring Access Through Medical Liability Reform bill, introduced in the last Congress by Senator Hatch (S. 2934, 101st Cong.), the Medicare Malpractice Dispute Resolution bill of 1990, introduced in the last Congress by Mrs. Johnson of Connecticut. The American Medical Association's Medical Liability Project, in its January 1988 report entitled "A Fault-Based, Administrative System" also recommends adoption of an administrative model.

If a state adopts the Malpractice Adjudication Act before Congress enacts the Federal Beneficiary Malpractice Adjudication Act, the state statute would apply to all federal beneficiaries and health care professionals and other health care providers over whom the state has jurisdiction, until enactment of the federal act. If a state does not adopt the Malpractice Adjudication Act within five years after the Secretary promulgates it, and Congress has enacted the Federal Beneficiary Malpractice Adjudication Act, the federal act would be opened to all malpractice claims arising in the state, at the option of either party.

Basis of Estimate and Key Assumptions

From a cost estimator's viewpoint, this proposal has two components: first, the additional costs associated with the administrative procedures put in place by the Act, and secondly, the savings that would accrue directly to Medicare, and indirectly to Medicaid and other federal programs from a reduction in malpractice awards caused by the Act.

The additional administrative costs were estimated from data on the costs of the administrative procedures currently in place for the disabilities determination process in the Social Security Administration. Based on that data and conversation with SSA budget staff, it would appear that approximately 800 additional federal staff would be required to administer the system. This would result in an additional cost of \$50 million in FY 1995.

The savings from this proposal result from two sources. First, there would be a reduction in increases of Part A costs of due to a decrease in the DRG update factor. The DRG update factor is estimated annually by the Office of the Actuary in the Health Care Financing Administration (HCFA). As part of the calculation of the update factor, the estimated future cost of malpractice is estimated. Future Medicare Part A DRG update costs are therefore reduced by the degree to which future malpractice costs are reduced. It is absolutely clear that this proposal would decrease malpractice costs. Unfortunately, after an extensive effort to locate data on the distribution of malpractice claims by award amount, this estimator was unable to locate a reliable distribution upon which to base this estimate. Extensive anecdotal, local, and sporadic data exist to document that many malpractice awards exceed the limit contained in the proposal. However, reliable data on the dollar value of these awards could not be located. Given the fact that savings would occur but the unknown magnitude was, this estimator made the assumption that the HCFA actuaries would reduce their estimate of malpractice costs by 10 percent. This leads to savings of approximately \$30 million in FY 1995.

The second source of savings from this proposal would be reductions in the "defensive medicine" behavior of physicians. A extensive literature exists on the costs to the health care system of defensive medicine. There is little doubt that this behavior exists and that it adds to the costs of federal health programs, such as Medicare. Unfortunately, estimates of the quantitative impact of the behavior are a small subset of the literature. This author reviewed over twenty such studies and contacted several of the authors. In spite of the wide range of estimates of savings found in the literature (from 5 percent to 25 percent of program costs), most experts and the literature agreed that the savings to the Medicare program would principally occur in two ways:

First, savings from an effective reduction in defensive medicine behavior by physicians would result in reduced laboratory tests under Part B. Interestingly, most experts said that these savings would be on the order of 5 percent to 15 percent, a much narrower range than

that found in the literature. Based on all available evidence, this estimate assumes that laboratory tests ultimately would be reduced by 10 percent. It should be noted that these savings occur in both direct billings for laboratory procedures and indirect billings for office and clinic-based procedures under Part B.

Second, although the literature and the experts agreed that a considerable number of unnecessary tests and procedures are performed on Medicare beneficiaries in hospitals, savings to the federal government would primarily occur as a result of reduced admissions since Part A primarily reimburses on a per admission basis. Almost all experts agreed that hospitals would benefit extensively from a reduction in unnecessary admissions. How many unnecessary admissions would be avoided by an effective malpractice adjudication program? The literature and experts were in relative agreement that this would be less than 2 percent of all admissions. This estimate assumes that by the end of year three, approximately one-half of 1 percent of all admissions would be avoided.

A combination of the foregoing two factors results in a reduction of \$330 million dollars in Medicare spending by FY 1995. This estimate can be criticized from several viewpoints. On the one hand, literature and expert opinion exists that could substantiate a much larger estimate of the effect of an effective malpractice reform package. On the other hand, this estimate can be criticized as optimistic over the ability of the federal government to implement a program successfully within three years and for physicians to alter their behavior in so short a period. Clearly, the estimate could be wrong on both counts. However, this estimator believes that on net, these two assumptions are reasonable.

Estimate

Table 8

**ESTIMATE OF COSTS ALTERNATIVE PROCEDURE TO
ADJUDICATE MALPRACTICE CLAIMS:
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outlays				
1. Costs of Administering Program ¹	10	40	50	100
2. Program Savings	0	5	-380	-375
Total	10	35	-330	-285

¹ Appropriated Amounts

PROPOSAL 9

INCREASING ACCESS TO PRIMARY CARE

The Proposal

In order to improve access to primary care, the Council recommends that \$250 million in new federal funding should be made available to establish 250 new community health centers, to be located in underserved areas or in areas with high concentrations of underserved target populations. The Secretary shall see that 20 of these new centers are targeted toward providing emergency care in areas without such services. An additional \$290 million should then be provided in annual operating funds.

In other respects, the Council has concluded that the existing authorities of the Department of Health and Human Services, if properly employed and financed, are sufficient to address the problems described. It strongly recommends that the Secretary of Health and Human Services and the Assistant Secretary for Health instruct the National Health Service Corps to revise its priorities focusing more attention on demonstrated unmet need.

Specifically, NHSC should work within its authorities to increase the access of target populations to primary medical care, *i.e.*, the urban and inner-city poor, especially infants and children; high-risk pregnant women; migrant workers and their families; drug and alcohol abusers, and the homeless. A \$100 million grant for this purpose is proposed by the council.

The NHSC should encourage primary care physicians to serve in community and migrant health centers, or in related health programs, or in underserved rural areas, and offer them incentives for efficient private practice in the areas in which they locate.

To facilitate implementation of the proposed instructions, the Advisory Council also recommends that the Corps prepare a written plan describing the actions that it will take so as to refocus its activities as described. The plan should contain measures by which its success can be measured objectively, and, after approval by the Secretary, should be published in the Federal Register.

Basis of the Estimate and Key Assumptions

This proposal does not require an estimate since the appropriated amount is specified in the proposal. However, it should be noted that approximately 2.1 million new persons annually would be served by the new funds based on current per capita for community health centers. The new centers themselves also would serve other clients funded by Medicaid and other payors. If the new centers' client mix were approximately the same as that of existing centers, these new centers would provide service to approximately 4 million persons.

Technical Notes Concerning the Estimate

Considerable variation exists between migrant and community centers across the country in terms of per capita expenditures. This estimate assumes that the new centers approximate the average centers now in existence. To the degree to which the new centers differ in client population from the old centers, the estimate of the number of new people served would be in error.

Allocation between years is based on current CBO spendout rates.

Estimate

Table 9

**ESTIMATE OF COSTS OF INCREASING ACCESS
TO PRIMARY CARE:
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
1. Costs of Establishing Centers	160	90	0	250
2. Operating Expenses	0	210	290	500
3. Grant to NHSC	50	100	100	250
Total	210	400	390	1000

PROPOSAL 10
A PROPOSAL TO REDUCE INFANT MORTALITY

The Proposal

The Council proposes a major initiative to reduce infant mortality:

A. General Approach to Reducing Infant Mortality. Although many programs seek to reduce infant mortality, its incidence is bound up in societal problems not readily solved. The challenge to government is not to devise further programs, but to use more effectively those that exist. Accordingly, the following proposal seeks to sharpen institutional weapons already deployed.

B. A. Proposal in Outline. As part of a renewed attack on infant mortality, legislation should be proposed to:

1. Integrate the WIC program with the MCH Block Grant program. The restructured programs would be administered by the Department of Health and Human Services rather than the Department of Agriculture, but would continue to support activities now conducted under either program.
2. Require states to furnish locations at which an eligible woman could establish her entitlement, or that of her infant, both to MCH/WIC benefits and to Medicaid.
3. Introduce a simplified application form for MCH/WIC/Medicaid eligibility.
4. Use publicly financed providers for "one-stop shopping": i.e., a single location both for determining eligibility for all programs pertinent to infant mortality and for providing health services.
5. Support outreach activities to publicize the program's existence of the program to potential eligibles, and to make program funds available for transportation and child care to enable mothers to meet health care appointments.
6. Establish demonstration of incentives to encourage women to obtain prenatal and well-baby care.
7. Support a demonstration program of home visits.
8. Institute economies, such as managed care, in the provision of health services, and arrangements to ensure the quality of those services.

C. Additional Program Features.

1. Use of Modified Block Grant Mechanism. The integrated MCH/WIC program, like the existing MCH program, would be structured as a block grant to the states, controllable by annual appropriations action. It would, nevertheless, require participating states to meet program objectives described in paragraph IV.B.

2. Availability of Program Benefits. Food and services under the program would be available to all pregnant women and infants, regardless of income, although the state would be allowed to charge for food or services provided to individuals other than low-income mothers or children. In such case, the state would be required to scale those charges in proportion to the income, resources, and family size of the (non-low-income) individual assisted.

3. Supplemental Grants for High Risk Populations. The program would reserve a proportion of total grant funds for grants, by the Secretary, to states, and counties, for innovative approaches to enhancing the program for high-risk populations. The Secretary would be required to develop a system of priorities for awarding such grants, with preference to be given to assisting children with special health care needs, chronically underserved populations, and other populations within which infant mortality is significantly higher than the national average.

4. National Health Service Corps Priority. The Public Health Service Act would be amended to establish a priority for the assignment of National Health Service Corps primary care physicians to areas (whether or not "underserved") that are shown to suffer annual rates of infant mortality exceeding, by 50 percent or more, the average annual rate of infant mortality among the white female population of the United States.

5. Maternal and Child Health Information Program. The program would generate maternal and child health information at two levels:

a. Written Information. Within the federal administering agency, there would be created an Office of Maternal and Child Health Information. The Office would be responsible for developing and disseminating written information to women of child-bearing age within the United States.

b. Classes. As a condition of federal financial participation, a state would be required to develop classes in prenatal care, child-care, and child-nurture, making them accessible to pregnant women, mothers, fathers, and (within the limit of program resources) all other women of child-bearing age. The Office of Maternal and Child Health Information would be authorized to cooperate with the states in preparing written course materials.

6. Prenatal Care Incentives Demonstration. In order to encourage women, particularly low-income women, to avail themselves of services intended to reduce infant mortality and improve the nutrition and health of mothers and children, the demonstration program would offer incentives, in the form of additional subsidization of prenatal, obstetrical, and well-baby care.

7. Quality Assurance. Each provider would be required, as a condition of the contract with the state, to undertake to perform services for contract beneficiaries of the same quantity and quality provided to the provider's other patients or clients. A failure to perform would be a breach of contract that would make the provider liable for appropriate liquidated damages established under the contract (subject to the Secretary's regulations), and termination of the contract.

Basis of Estimate and Key Assumptions

This is a complex estimate with a number of components. It should be noted that this proposal would be more expensive if other proposals, such as the school based clinics, were removed from the package of proposals.

Integrate WIC/MCH Block Grants

Integration of the WIC program with the MCH Block Grant program would have no budget impact. The few department staff freed by the administration most likely would be reassigned to the other activities required by this proposal. Hence, this portion of the proposal would have no costs or savings.

Simplification of Application Process

The proposal requires states to: (1) increase the number of intake sites, (2) simplify the application form, and (3) institute "one-stop shopping". Based on the experience of six states currently being analyzed by HCFA, such efforts increase Medicaid costs due to increased coverage during the verification phase of the application process. The estimate of these costs assumes that approximately 10 percent of applicants would benefit for an average of 60 days from the simplification process.

Outreach Activities

The proposal requires states to publicize the program's existence to potential eligibles, and to make program funds available for transportation and child care to enable mothers to meet health care appointments. Outreach activities for this group are assumed to cost \$20 million per year. These outreach activities will yield an increased number of Medicaid eligibles. Using the limited experience of California in such activities for this particular group, it would appear that an additional 200,000 persons would be enrolled and services to an

additional 500,000 children would increase. Per capita's for these groups were taken from Medicaid statistical data.

Demonstrations of Incentives

The proposal requires the Secretary to establish demonstrations of incentives to encourage women to obtain prenatal and well-baby care. The demonstrations are to be appropriated at \$10 million per year and therefore do not require estimation.

Demonstrations of Home Visits

The proposal requires the Secretary to establish demonstration programs of home visits. The demonstrations are to be appropriated at \$10 million per year and therefore do not require estimation.

Table 10

COSTS OF A PROPOSAL TO REDUCE INFANT MORTALITY
Numbers in Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Integrate WIC/MCH Block Grants	0	0	0	0
Simplification of Application Process	70	100	120	290
Outreach Activities	50	250	330	630
Demonstrations of Incentives	2	10	10	22
Demonstrations of Home Visits	2	10	10	22
Total	124	370	470	964

PROPOSAL 11

PROMOTING EMPLOYER-BASED HEALTH INSURANCE

THE PROPOSAL

Model State Law. The Secretary of Health and Human Services would develop and promulgate a model law, for adoption by the several states, that would apply to a group health benefit plan covering employers of from 2 to 50 employees. Plans for small employers would be required to meet a number of conditions governing the exclusion of employees for pre-existing conditions, renewability, the use of medical underwriting, availability, denial because of risk, waiting periods for coverage, premium variations among groups, and annual premium increases.

All insurers within the state would agree on risk categories that would place employees of all or many small employers within the state into one or more statewide risk groups. Among possible sources of revenue to fund the risk pool, the state could enact legislation to assess all employers within the state for contributions.

If insurers within a state do not establish a pooling arrangement, the state would establish a reinsurance pool in which all insurers within the state would participate, and which would reinsure such policies so as to reduce their cost. All carriers and other organizations issuing health benefit plans would be members of the program, including Blue Cross and Blue Shield. Nevertheless, Blue Cross and Blue Shield would be permitted to manage their own reinsurance risk if they (jointly) choose to do so.

If a state does not adopt the model legislation within three years after the Secretary promulgates it, the standards for insurance policies under the model act shall go into effect as federal standards for all policies offered to small employers within the state.

Disallowance of State-Mandated Benefits for Small-Employer Core Health Benefit Plans. The proposal would relieve health care insurers, and other organizations that offer health benefit plans to employers, from state requirements that health insurance policies for small employers limited to core benefits contain specified additional benefits, and cover services by designated categories of health care providers.

Preemption of State Laws Limiting the Use of Managed Care in Health Benefit Plans. The proposal would relieve health care insurers from state limitations on the use of managed care. In order to safeguard the patient from the erection of unreasonable barriers to adequate medical treatment that this superseding might invite, the Secretary of Health and Human Services, through a formal rulemaking process to redefine the term "managed care," would establish standards for alternative limitations that a state could impose. State laws would cease to apply that currently inhibit carriers from contracting with providers, restrict carriers'

ability to negotiate with providers regarding reimbursement, and restrict the inclusion of financial incentives to patients in managed care Plans.

Improving the Portability of Private Health Insurance. The proposal, through an amendment to the tax law, would induce health insurers to extend employer-based health plan coverage to new employees with a history of recent prior health coverage, without imposing restrictions relating to pre-existing health conditions, claims experience, receipt of health care, medical history, or lack of evidence of insurability.

Basis of Estimate and Key Assumptions

This estimate has two parts from a cost estimator's viewpoint: first, the administrative costs associated with developing the new legislation, and secondly, the costs of operating the program. Developing the legislation is well within the resources available to the Secretary in the Assistant Secretary for Legislation's staff. Hence, development of the legislation and model law would not increase federal expenditures. Similarly, the proposal indicates that the costs of the program and its administration would be funded by the premiums. Again, there would be no cost to the federal government.

Estimate

Table 11

**COSTS OF A PROPOSAL PROMOTE EMPLOYER-BASED
HEALTH INSURANCE:**

Numbers in Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Appropriated Amounts				
1. Costs of Development of Legislation	0	0	0	0
2. Program Operation	0	0	0	0
Total	0	0	0	0

PROPOSAL 12
HEALTH INSURANCE FOR THE SELF-EMPLOYED

The Council recommends that the Treasury Department review the deductibility of health insurance premiums paid by the self-employed, with a view to proposing an amendment of the tax laws that would place the self-employed on the same footing, in regard to the tax treatment of premiums for health insurance coverage, as employees.

Estimate and Key Assumptions

The staff necessary for these activities would be drawn from the agency staff. It would not increase federal expenditures.

Estimate

Table 12

HEALTH INSURANCE FOR THE SELF-EMPLOYED:
Numbers in Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outlays	0	0	0	0

PROPOSAL 13
A PROPOSAL TO REDUCE THE PAPERWORK ASSOCIATED
WITH HEALTH CLAIMS

The Proposal

The Health Care Financing Administration will review its major hospital billing form in 1992. The council recommends that legislation be developed to give guidance to that process.

A. The Objective. Legislation guides the process in three ways:

1. By providing a framework to facilitate discussions.
2. By clearly defining its objective.
3. By establishing an alternative process if the discussions are unsuccessful.

B. Advisory Council. The proposal would direct the Secretary to convene the Advisory Council on Hospital Reimbursement Procedures, to consist of 15 individuals, including representatives of the American Hospital Association, the American Medical Association, the Health Insurance Association of America, individual hospitals and health care insurers, and the Health Care Financing Administration. At least five members of the Council would be required to be currently employed as hospital administrators.

C. Responsibility of the Council. The proposal would direct the Council, within three years of its appointment, to recommend to the Secretary, a uniform hospital reimbursement form, which, when promulgated by the Secretary's regulations, would be the sole form required by the Health Care Financing Administration or any private health care insurer in the United States as the sole basis for making payment on a claim for reimbursement for hospital in-patient services.

D. Contents of a Uniform Reimbursement Form. The uniform reimbursement form, as recommended by the Council, shall include:

1. Uniform Clinical Data Set. A diagnosis of the patient based on a uniform clinical data set.²

² The Institute of Medicine has recently recommended development of electronic medical records, with all patient information going into the record. The proposal, under development

2. Procedures Employed. A uniform coding of medical procedures used to treat the patient.

3. Billing Information. Reimbursement requested for each procedure employed with respect to the patient, including hospital services, physician's services, X-rays, tests, rehabilitative services, and so forth, as may be required to ensure that the form is comprehensive.

E. Report on Computerization of Billing. The Council would also report on the computerization of health claim billing, i.e., the use of electronic means to transmit billing information from hospitals and physicians to insurers and HCFA. The report would include:

1. a survey of the current state of electronic billing;
2. a discussion of the impediments to more extensive use of electronic billing;
3. an analysis of the probable costs of increasing the volume and standardization of such billing in relation to the savings to the health care system that could reasonably be anticipated, and
4. the Council's recommendations for action that would facilitate the further extension of electronic billing in a cost-effective manner.

F. Development of Form By HCFA if the Council Fails to Agree. If, at the end of two years after the Secretary has appointed the members of the Council under the proposal, the Council fails to recommend a uniform hospital reimbursement form, as required under paragraph II.C, the Secretary shall direct the Health Care Financing Administration to develop and promulgate such a form for the purpose within six months.

Basis of Estimate and Key Assumptions

This estimate has two parts from a cost estimator's viewpoint: first, the administrative costs associated with developing and changing the new uniform bill, and secondly, the potential savings from increased efficiencies. The costs of the Advisory Council were estimated from data supplied by the Department's management staff who indicated that several similar advisory groups cost approximately \$1 million per year.

The major cost of changing the uniform bill would be the cost of reprogramming in the fiscal intermediaries and HCFA computers. Based on extensive conversations with current and

as "Quality 2000" in conjunction with congressional legislative staff, would mandate electronic data collection for hospitals by the year 2000.

former HCFA staff involved in the last major reform of the hospital billing form, it will cost approximately \$50 million for HCFA and the intermediaries to revise the forms.

Savings from changing the form could not occur until after the form was implemented. Assuming the form was available at the end of 1994, based on the last revision of the bill, it would be at least two more years before HCFA, fiscal intermediaries, and hospitals were able to implement the form and realize savings. Although that is beyond the period being estimated, this estimator believes that some savings to the Medicare program would be realized by a streamlined billing process.

Estimate

Table 13

A PROPOSAL TO REDUCE PAPERWORK ASSOCIATED WITH HEALTH CLAIMS
Numbers in Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Appropriated Amounts				
1. Costs of Computer Conversion	0	0	50	52
2. Costs of Advisory Council	1	1	0	0
Total	1	1	50	52

PROPOSAL 14

HOSPITAL MERGERS AND JOINT VENTURES

The Proposal

The Advisory Council recommends that certain antitrust and Medicare fraud and abuse laws and regulations be amended to permit certain types of hospital mergers and joint ventures. Specifically:

A. Hospital Mergers The Council would propose that the Attorney General develop proposals for legislation amending the antitrust laws to permit mergers of two hospitals in the same community in limited cases. The proposed legislation should include criteria relating to the length of time each hospital has served the community, the occupancy rate and relative financial condition of each hospital, and the willingness of each hospital to engage in the merger.

B. Joint Ventures The Council would propose that the Attorney General and the Secretary of Health and Human Services jointly develop proposals for legislation amending the antitrust laws to permit two hospitals in the same community, in limited cases to enter into a joint venture for the provision of hospital services at one facility and health-related services (such as long-term care or outpatient care) at the other hospital facility. The proposed legislation should include criteria relating to the length of time each hospital has served the community, the occupancy rate and relative financial condition of each hospital, the types of services to be provided by the joint venture, and whether the new services to be provided meet an unmet need in the community.

Basis of the Estimate and Key Assumptions

This proposal has two components from a cost estimator's point of view: first, possible costs associated with developing the legislative proposal, and secondly, potential secondary costs and savings associated with increased efficiencies when services are delivered in a coordinated manner in a particular community.

The development of the legislative proposals called for by the Council appears well within the resources allocated by the Departments to existing Offices charged with developing legislative proposals. Hence, the estimate for this portion of the Council's proposal is zero.

The second potential effect on federal outlays of this proposal would be increases and/or decreases in Medicare, Medicaid, and other program costs as a consequence of the new provider arrangements fostered by the eventual implementation of the legislation. For example, it can be argued that savings will occur due to the better coordination within communities of outpatient services between the existing hospitals. On the other hand, it can

be argued that program outlays will increase due to unmet needs within the communities. Data directly relevant to estimate either the costs or savings is nonexistent. Even if such data did exist, a considerable number of assumptions concerning the behavior and timing of hospitals would be required to develop an estimate. Finally, such savings and costs would appear well outside the time frame being estimated, fiscal years 1993 to 1995, since development and passage of the legislation would take at least that long. For these and other reasons, costs and savings of this proposal are not estimable and a zero has been assigned. It should be noted that this position on estimates of this type is also the position taken by CBO and the HCFA Office of the Actuary on a number of similar proposals.

Estimate

Table 14

**ESTIMATE OF COSTS OF HOSPITAL MERGERS
AND JOINT VENTURES:
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outlays ³				
1. Costs of Developing Legislation	0	0	0	0
2. Savings from Increased Efficiencies	0	0	0	0

³ The costs of developing the proposals would be appropriated amounts. However, costs and savings to Medicare, Medicaid, and other federal programs would be outlays from the federal Treasury if they could be estimated.

PROPOSAL 15

A PROPOSAL TO ESTABLISH CENTERS OF EXCELLENCE

The Proposal

It is proposed to reimburse health care providers, under Medicare, for the costs of performing designated major medical or surgical procedures -- procedures employed for certain life-threatening or seriously disabling conditions and typified by their high cost and low volume -- only if those procedures are performed in facilities meeting rigorous criteria of quality.

The proposal would channel patients for those procedures to facilities most successful in performing them and discourage their performance at less successful facilities.

Because a consequence of the proposal would be to reduce the number of facilities at which the designated procedures could be performed, it is also proposed to reimburse a Medicare beneficiary for the cost of travel between the facility and the beneficiary's place of residence.

A. Procedures Designated. In order to be designated, by the Secretary of Health and Human Services, as a procedure the performance of which will be reimbursed by Medicare only if performed at a designated facility, the procedure must first be assessed by the Office of Health Technology Assessment of the Public Health Service and found to be:

1. safe,
2. effective,
3. necessary to alleviate a life-threatening or seriously disabling condition, and
4. a relatively low-volume procedure requiring a major case management effort.

B. Criteria to be Met by a Selected Facility. To be selected as a facility for the performance of a procedure designated under this proposal, the Secretary must find that the facility meets the following criteria:

1. Patient Selection. It must have written patient selection criteria which it would follow in determining suitable candidates for the procedure. Patient selection criteria must be based upon both a critical medical need for the procedure and a maximum likelihood of successful clinical outcome.

2. Patient Management. It must have adequate patient management plans and protocols that include the following:

- a. Therapeutic and Valuable Procedures.

Therapeutic and valutive procedures for the acute and long-term management of a patient, including commonly encountered complications.

b. Patient Management and Evaluation.

Patient management and evaluation during the waiting and immediate post-discharge period, as well as in-hospital phases of the program for performing the procedure.

c. Long-term Management and Evaluation.

Long-term management and evaluation, including education of the patient, liaison with the patient's attending physician, and the maintenance of active patient records for at least five years.

3. Commitment. A facility must make a sufficient commitment of resources and planning to the program for performing the procedure to carry through its application. Indications of this commitment should include the following:

a. Commitment at All Levels.

Commitment of the facility to the program at all levels, including, as necessary, other departments of the facility as well as the principal sponsoring departments.

b. Adequate Expertise.

The facility must be expert in medical, surgical, and other relevant areas, including an identifiable and stable team for performing the procedure, the responsible members of which are board certified or otherwise approved by the Secretary.

(1) Integration of Teams.

The component teams must be integrated into a comprehensive team with clearly defined leadership and corresponding responsibility.

(2) Anesthesia.

The anesthesia service must identify a team for performance of the procedure that is available at all times.

(3) Infectious Disease.

The infectious disease service must have both the professional skills and laboratory resources needed to discover, identify, and manage the

complications from a whole range of organisms, many of which are uncommonly encountered.

(4) Nursing Service.

The nursing service must identify a team or teams trained in the special problems of managing patients who undergo the procedure.

(5) Pathology Resources.

Pathology resources must be available for studying and reporting promptly any pathological responses to the procedure.

(6) Social Services.

Adequate social services resources must be available.

(7) Patient Selection.

Mechanisms must be in place to ensure that:

(a) patient selection

criteria are consistent with those set forth in the facility's written patient selection criteria, and

(b) the facility is

responsible for the ethical and medical considerations involved in the patient selection process and application of patient selection criteria.

(8) Plans for Organ Transplantation.

If the procedure involves organ transplantation, that adequate plans exist for organ procurement meeting legal and ethical criteria, as well as yielding viable transplantable organs in reasonable numbers.

4. Facility Plans. The facility must have overall facility plans, commitments, and resources for a program that will ensure a reasonable concentration of experience. The Secretary of Health and Human Services would establish the frequency with which the facility must perform the procedure. This level of activity must be shown feasible and likely on the basis of plans, commitments, and resources.

5. Experience and Survival Rates. The facility must demonstrate experience and success with the procedure. Survival rates must meet criteria established by the Secretary.

6. Maintenance of Data. The facility must agree to maintain and, when requested, periodically submit data to the Secretary, in standard format, about patients selected (including patient identifiers), protocols used, and short- and long-term outcome on all patients who undergo the procedure, not only those for whom payment under Medicare is sought.

7. Laboratory Services. The facility must make available, directly or under arrangements, laboratory services (including blood banking) to meet the needs of patients. Laboratory services must be performed in a laboratory facility approved for participation in the Medicare program.

C. Reimbursement of Beneficiary. In addition to such other reimbursement as the Medicare statute may provide, a beneficiary may be reimbursed for travel to and from a selected facility if the beneficiary resides more than 50 miles from the facility.

Basis of the Estimate and Key Assumptions

This estimate is based on information from two sources: first, data and conversations with individuals familiar with Medicare's heart transplant centers, and secondly, with State Medicaid agencies that have had experience with hospital contracting. The Medicare heart transplant centers use very similar types of approaches to those suggested by this proposal, with the exception that cost effectiveness was not an explicit goal in the selection of these centers. The State Medicaid agency staff were a primary source of information concerning what, realistically, one might consider obtaining through a contracting approach.

The data and conversations with persons knowledgeable with the heart transplant centers yielded a relative consensus that transportation of patients, which is often necessary, rarely exceeds 5 percent of the total cost of the hospitalization, with the rare exception being a very large air ambulance bill. In contrast, there was wide variation among these and Medicaid respondents on the level of savings that could be expected from a contracting approach. Of the eight persons interviewed, the low estimate was 5 percent and the high estimate was 25 percent. Given the wide variation and lack of hard data in this area, this estimate assumes that Medicare would save 15 percent per admission through a contracting approach, and that it would add 5 percent per admission for beneficiary travel, for a net savings of 10 percent per admission.

The most difficult part of this estimate is to make assumptions on how quickly the Secretary would move, and on how many procedures involving how many admissions. Clearly, the first year, FY 1993, would be required to develop the guidelines and begin the contracting process. Aside from that, what the Secretary might do is difficult to project. Given the

intent of the proposal, liver and other high-cost procedures clearly would be immediate candidates for this selective contracting. By 1993, Medicare Part A and B expenditures for these patients would appear to be on the order of \$80 million. Experts estimated that approximately 75 percent of all cases were of a non-emergency nature and would be amenable to a center of excellence approach. Hence, assuming that the Secretary was able to get 20 percent of the admissions under contract in 1994 and 40 percent in 1995, Medicare would save \$10 million in FY 1995.

The above assumptions are conservative and could be characterized as a low estimate. If the Secretary were to include three other procedures and get 50 percent of the admissions under contract in 1994 and 70 percent in 1995, assumptions not outside the realm of possibility, the savings would rise to \$30 million in 1995.

Estimate

Table 15

A PROPOSAL TO ESTABLISH CENTERS OF EXCELLENCE
Numbers in Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outlays				
Low Estimate	0	-5	-10	-15
High Estimate	0	-10	-30	-40

PROPOSAL 16
A PROPOSAL TO CONTAIN MEDICARE COSTS THROUGH
USE OF SELECTED CONTRACTING

The Proposal

The Council proposes to institute a system, under Medicare, whereby the program will reimburse a provider for the costs of performing a designated medical or surgical procedure - a procedure typified by its high cost to the program -- only if Medicare has first approved the provider for the performance of that procedure.

The proposal's objective is to channel patients for those procedures to facilities that have qualified as cost-efficient.

ELEMENTS OF THE PROPOSAL

A. Procedures Designated. The Secretary of Health and Human Services may designate a medical or surgical procedure as reimbursable by Medicare, only if performed at an approved facility, and if:

1. the Secretary determines that the procedure is one that imposes high costs on the Medicare program, and
2. the Office of Health Technology Assessment of the Public Health Service has assessed the procedure and found it to be safe, effective, and necessary to alleviate a life-threatening or seriously disabling condition.

B. Qualification of Facility.

1. Competitive Bidding. The Secretary would be required to develop administrative arrangements under which criteria would be published for the selection of facilities to perform each procedure designated under the program, and bids from such facilities would be solicited and evaluated.

2. Fixed Charge. All services delivered by a provider would be on the basis of a fixed charge per procedure for all hospital and physician services (including post-operative care) associated with the procedure, regardless of the actual cost of the procedure in a particular case.

C. Quality Assurance Standards. To be approved as a facility for the performance of a procedure under this proposal, the facility must meet the following criteria:

1. Patient Selection. It must have written patient selection criteria which it would follow in determining suitable candidates for the procedure. Patient selection criteria must be based upon both a critical medical need for the procedure and a maximum likelihood of successful clinical outcome.

2. Patient Management. It must have adequate patient management plans and protocols that include the following:

a. Therapeutic and Valuable Procedures. Therapeutic and valuable procedures for the acute and long-term management of a patient, including commonly encountered complications.

b. Patient Management and Evaluation. Patient management and evaluation during the waiting and immediate post-discharge period, as well as in-hospital phases of the program for performing the procedure.

c. Long-Term Management and Evaluation. Long-term management and evaluation, including education of the patient, liaison with the patient's attending physician, and the maintenance of active patient records for at least five years.

3. Commitment. A facility must make a sufficient commitment of resources and planning to the program for performing the procedure to carry through its application. Indications of this commitment should include the following:

a. Commitment at All Levels. Commitment of the facility to the program at all levels, including, as necessary, other departments of the facility as well as the principal sponsoring departments.

b. Adequate Expertise.

The facility must be expert in medical, surgical, and other relevant areas, including an identifiable and stable team for performing the procedure, the responsible members of which are board-certified or otherwise approved by the Secretary.

4. Facility Plans. The facility must have overall facility plans, commitments, and resources for a program that will ensure a reasonable concentration of experience. The Secretary of Health and Human Services would establish the frequency with which the facility must perform the procedure for the conditions for which the facility must perform the procedure. This level of activity must be shown feasible and likely on the basis of plans, commitments, and resources.

5. Experience and Survival Rates. The facility must demonstrate experience and success with the procedure. Survival rates must meet criteria established by the Secretary.

6. Maintenance of Data. The facility must agree to maintain and, when requested, periodically submit data to the Secretary, in standard format, about patients selected (including patient identifiers), protocols used, and short- and long-term outcome on all patients who undergo the procedure, not only those for whom payment under Medicare is sought.

Basis of the Estimate and Key Assumptions

This estimate is based on information from two sources: First, data from the Medicare Part A and Part B bill files, and secondly, conversations with State Medicaid agencies that have had experience with hospital contracting. The Medicare bill file provided estimates of the costs of the procedure in question. The State Medicaid agency staff were a primary source of information concerning what, realistically, one might consider obtaining through a contracting approach.

The first part of this estimate involves assumptions on how many procedures involving how many admissions the Secretary would move to place under contracting, and how quickly the Secretary would move. Clearly, the first year, FY 1993, would be required to develop the guidelines and begin the contracting process. It appears reasonable to assume that the Secretary might also initially select a major cost procedure for contracting. The office of Demonstrations and Evaluations is currently conducting a contracting demonstration. By FY 1993, Medicare Part A and B expenditures for these patients would appear to be more than \$3.6 billion. Hence, assuming that the Secretary was able to get 20 percent of the admissions under contract in FY 1994 and 40 percent in FY 1995, combined with the proposal's other assumptions, a contracting approach would save \$170 million in FY 1995.

The above assumptions are conservative and could be characterized as a low estimate. If the Secretary were to include three other procedures and get 50 percent of the admissions under contract in FY 1994 and 70 percent in FY 1995, assumptions not outside the realm of possibility, the savings would rise to \$530 million in FY 1995.

Estimate

Table 16

**A PROPOSAL TO CONTAIN MEDICARE COSTS
THROUGH THE USE OF SELECTED CONTRACTING
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outlays				
Low Estimate	0	-60	-170	-230
High Estimate	0	-110	-530	-640

PROPOSAL 17
MERGING MEDICARE PARTS A AND B

The Proposal

The Advisory Council would recommend that the Medicare law be amended to combine Parts A and B into one program. The three separate funding sources -- payroll taxes, general revenues, and premiums for Part B -- would remain, and a method would be developed by HCFA to maintain the integrity of the relative share of program costs for purposes of determining the Part B premium.

Combining Parts A and B has several advantages. The Medicare program would be viewed as a single unified program, with common administrative and management goals. The impact of program expenditures could be evaluated and analyzed in terms of their total impact on the economy, and a unified portrayal of the long-range obligations of the program could be accomplished.

Estimate and Key Assumptions

Combining Parts A and B of Medicare has been proposed by members of Congress on several occasions in the last several years. The Congressional Budget Office (CBO) has estimated that there would be no savings or costs from such legislation. They have rejected the argument that administrative efficiencies would occur on the grounds that the nature of such efficiencies is unclear, and in any event it would take years before the Health Care Financing Administration (HCFA) would implement such programs' economies. This estimator concurs with CBO's estimate.

Estimate

Table 17

MERGING MEDICARE PARTS A AND B:
Numbers in Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outlays	0	0	0	0

PROPOSAL 18

TASK FORCE ON INVESTMENT IN HUMAN RESOURCES

The Proposal

The Council would recommend that the President establish an Interagency Task Force on Investment in Human Resources.

Composition. The Task Force would be chaired by the Secretary of Health and Human Services and would include:

- (1) the Secretary of Agriculture;
- (2) the Secretary of Education;
- (3) the Secretary of Housing and Urban Development;
- (4) the Secretary of Labor; and
- (5) the heads of such other Federal agencies as the President considers appropriate.

Mission. The Task Force would be charged with developing a comprehensive interagency strategy to improve investment in American human resources and society, and thereby improve productivity and competitiveness. Areas to be considered by the Task Force would include:

(1) the identification of problems in education, housing, nutrition, and alcohol and drug abuse which have an effect on health status, as well as the resulting effects on productivity and competitiveness;

(2) the development of a comprehensive five-year strategy detailing how Federal agencies can address the problems identified, including:

(A) the development of a plan that includes a process so that Federal agencies can work together to minimize duplication in programs addressing these problems and maximize the use of existing resources;

(B) a list of actions that can be taken by Federal agencies, without changes in law, to implement the strategy, and

(C) a timetable for implementation of the strategy and a plan for evaluating and ensuring that the timetable is met.

(3) recommendations for changes in law that would be necessary to further the strategy.

Report. The Task Force would prepare semiannual reports to the President containing updates on the implementation of the strategy and recommendations for legislation.

Staffing. Staff for the Task Force would be drawn from personnel of the agencies represented.

Estimate and Key Assumptions

This proposal specifies that the staff of the Task Force would be drawn from the agencies represented, hence, no estimate of this proposal is necessary. It would not increase federal expenditures.

Estimate

Table 18

**TASK FORCE ON INVESTMENT IN HUMAN RESOURCES:
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outlays	0	0	0	0

PROPOSAL 19

PROMOTING HEALTHY LIFESTYLES

The Proposal

The Council recommends that the President's Council on Physical Fitness undertake a program to:

A. Develop Measures to Discourage The Use of Tobacco.

1. Advertising Ban. The proposal would ban all forms of advertising tobacco and tobacco products.
2. Vending Machine Ban. The proposal would ban the sale of cigarettes from vending machines.
3. Termination of Tobacco Subsidy. The proposal would phase out tobacco subsidies, under a program that would offer loans and other short-term assistance to farmers in order to facilitate conversion to other crops.

B. Encourage Healthy Lifestyles. The proposal⁴ would establish a statutory foundation for the development and implementation of programs to encourage healthy lifestyle choices, such as:

- avoiding illegal drugs;
- avoiding excessive alcohol consumption;
- avoiding the use of tobacco products;
- choosing proper foods as components of a healthy, balanced diet;
- developing effective ways to manage stress; and
- engaging in regular exercise.

C. Use Current Programs and Activities. The administering agency would promote this new concept of physical fitness by:

⁴. One approach might be to reconstitute the President's Council on Physical Fitness and Sports as a statutory body and expand its functions.

- enlisting the active support of private citizens, civic groups, business enterprises, foundations, and other entities in efforts to promote healthy lifestyle choices by all Americans;
- initiating activities to inform the general public of the importance of healthy lifestyle choices, and of the link between appropriate lifestyle behaviors and good health and productivity;
- encouraging state and local governments to emphasize to their citizens the importance of making healthy lifestyle choices;
- advancing the concept of physical fitness through healthy lifestyle choices, systematically encouraging the development of community programs;
- developing cooperative programs with societies of health professionals to encourage Americans to make healthy lifestyle choices;
- assisting educational agencies at all levels to develop high quality, innovative health and physical education programs that emphasize the importance of making the right lifestyle choices for good health, and
- helping business, industry, government, and labor organizations, encouraging public/private ventures which establish programs to promote healthy lifestyle choices by their employees and to reduce the financial and human costs resulting from inappropriate lifestyle choices.⁵

Basis of the Estimate and Key Assumptions

The estimate assumes that existing Council on Physical Fitness and Sports staff would redirect part of their efforts to include the themes recommended by the Advisory Council in existing publication and activities. For example, the proposal does not mandate an overall increase in the presidential Council's publication budget. The estimate assumes small additional costs to modify the publications based on examination of the Presidential Council's budget and conversations with the Council's staff on publication costs.

⁵. The new program would assume only those current activities of the President's Council on Physical Fitness and Sports directed towards exercise and sports; *i.e.*, promotion of research in sports medicine, physical fitness, and sports performance, and coordinating Federal agency activities related to physical fitness and sports. This would be accomplished either by expanding the mission of the Council to enable it to administer the proposal, by transferring the Council to the agency administering the proposal, or by abolishing the Council altogether.

Estimate

Table 19

**ESTIMATE OF COSTS OF PROMOTING HEALTHY LIFESTYLES
THROUGH THE PRESIDENT'S COUNCIL ON PHYSICAL FITNESS:
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Appropriated Amounts	.2	.2	.3	.7

PROPOSAL 20
POOLING OF DATA FOR TECHNOLOGY ASSESSMENT

The Proposal

The Council would recommend that the Attorney General and the Secretary of Health and Human Services jointly develop proposals for legislation to amend the antitrust laws, permitting hospitals and insurance companies to compare and pool data for the purpose of developing improved methods of technology assessment and medical evaluation.

Basis of the Estimate and Key Assumptions

Both the Attorney General and the Secretary of Health and Human Services have existing staffs charged with development of legislation. Hence, this proposal has no cost implications.

Estimate

Table 20

POOLING OF DATA FOR TECHNOLOGY ASSESSMENT:
Numbers in Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outlays	0	0	0	0

PROPOSAL 21

PRESIDENT'S COUNCIL ON FITNESS FOR THE MIDDLE AND SENIOR YEARS

THE PROPOSAL

In General. It is proposed that there be established, as a companion body to the President's Council on Physical Fitness and Sports, a President's Council on Senior Fitness, which shall be within the Department of Health and Human Services. The Council shall focus on the development of programs especially suited to an individual's middle and later years.

Appointment. The President shall appoint 20 members to the Council, and shall designate a Chairman and Vice Chairman.

National Program. The Council shall—

1. enlist the active support and assistance of individual citizens, civic groups, private enterprise, voluntary organizations, and others in efforts to promote and improve the fitness of all Americans over the age of 50 through regular participation in suitable programs of physical fitness;
2. initiate programs to inform the general public of the importance of exercise and the link that exists between regular physical activity and good health and effective performance;
3. strengthen coordination of federal services and programs relating to physical fitness of individuals over age 50;
4. encourage State and local governments to emphasize the importance of regular physical fitness for older citizens,
5. encourage research in physical fitness for older individuals;
6. assist business, industry, government, and labor organizations to establish sound physical fitness programs to reduce the financial and human costs of physical inactivity.

Coordination. The Council shall seek to coordinate its activities with those of the President's Council on Physical Fitness and Sports.

Other Functions. The Council shall advise the President and the Secretary of Health and Human Services as to its activities in devising and promoting programs to improve the fitness of older Americans.

Service of Members. The members of the Council shall serve without compensation for their work on the Council, but will be entitled to travel and subsistence expenses for meetings.

Staff. The Secretary of Health and Human Services shall provide the Council with a suitable staff and facilities.

Estimate and Key Assumptions

The estimate for the cost of the council was based on costs of similar councils. Obviously, the scope of the councils activities would depend on the funding level.

Estimate

Table 21

**PRESIDENT'S COUNCIL FITNESS FOR THE MIDDLE AND SENIOR YEARS:
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Appropriated Amounts	2	5	5	12

PROPOSAL 22

A PROPOSAL TO DEVELOP INFORMATION ON MEDICAL TREATMENT OUTCOMES

The Proposal

The Department of Health and Human Services, through the Agency for Health Care Policy and Research (AHCPR), is supporting research on the appropriateness and effectiveness of alternative strategies for the prevention, diagnosis, treatment, and management of a variety of acute and chronic conditions, and along with other entities is developing medical practice guidelines for use by health care providers. Practice parameters, the development of which by the medical profession is strongly advocated by the American Medical Association, will encourage and enhance the delivery of the most appropriate care to each patient. They would supplement the physician's judgment in reducing unnecessary and inappropriate variation in the use of health care services and procedures.

The Advisory Council recommends that AHCPR focus its efforts on developing a system that would produce comprehensive reports on the performance of local and regional health care markets. The reports could be used to repair flaws in three critical policy areas: information, finance, and manpower. As proposed by Dr. Weinberg, reports would include the following information:

- the location of local and regional market areas,
- the per capita allocation of hospital beds, physician, and other manpower in each market;
- Utilization rates; and
- certain outcomes.

The reports would be invaluable for supporting alternative strategies for containing capacity. Information on outcomes of alternative treatment modalities, standing alone, would make a serious contribution to reducing supplier-induced demand.

Estimate and Key Assumptions

The staff necessary for these activities would be drawn from the agency staff. It would not increase federal expenditures.

Table 22

DEVELOP INFORMATION ON MEDICAL TREATMENT OUTCOMES:
Numbers in Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outlays	0	0	0	0

PROPOSAL 23
A PROPOSAL FOR A PUBLIC EDUCATION CAMPAIGN ON PREVENTION

The Proposal

It is proposed that the Surgeon General of the United States conduct a massive three year public education campaign on the prevention of disease through changes in personal behaviors and use of preventive care and screening. The campaign would involve a coordinated effort using the broadcast and print media, including public service announcements, outreach to community groups, and cooperative ventures with businesses. The campaign would also involve schools through design of curricula for use in health education classes as well as presentations on preventive health issues.

The Council suggests that the Advertising Council adopt this public education campaign on prevention as its entire effort during this three year period, and that the Surgeon General work with other groups, such as the National Association of Broadcasters, to implement this campaign.

Estimate and Key Assumptions

The staff necessary for these activities would be drawn from the agency staff. It would not increase federal expenditures. The public education activities would be funded by both the government and the organizations involved in the campaigns. The \$20 million contained in this estimate for the federal portion was supplied by Advisory Council staff.

Estimate

Table 23

PUBLIC EDUCATION CAMPAIGN ON PREVENTION
Numbers in Millions of Dollars by Fiscal Year

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outlays	10	20	20	50

Appendix D:

Prototype Reform Plans

***THE INSURANCE MARKET REFORM PROPOSAL:
ESTIMATED COST AND IMPACTS***

Prepared For:

The Social Security Advisory Council

Submitted By:

***Lewin/ICF
A Health and Sciences International, Inc.***

December 19, 1991

THE INSURANCE MARKET REFORM PROPOSAL

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OVERVIEW OF PLAN

- ***SMALL GROUP INSURANCE MARKET REFORM AND OTHER REFORMS TO MAKE INSURANCE MORE WIDELY AVAILABLE***
- ***MEDICAID EXPANSION FOR ALL PERSONS LIVING BELOW POVERTY REGARDLESS OF CATEGORICAL ELIGIBILITY***
- ***MEDICAID BUY-IN FOR PERSONS BETWEEN 100 AND 150 PERCENT OF POVERTY***

EMPLOYER BASED INSURANCE

- **EMPLOYER BASED COVERAGE IS ENCOURAGED AND FACILITATED RATHER THAN MANDATED**
- **THE SELF-EMPLOYED WOULD BE ABLE TO DEDUCT 100 PERCENT OF THE COST OF HEALTH INSURANCE**
 - *The deduction for self-employed persons is currently limited to 25 percent of benefit costs.*
 - *The self employed are already permitted to deduct the full cost of benefits for workers.*
- **SMALL EMPLOYERS (FEWER THAN 25 EMPLOYEES) WILL BE PROVIDED A REFUNDABLE TAX CREDIT FOR EMPLOYEE HEALTH BENEFITS COSTS IN EXCESS OF FIVE PERCENT OF GROSS REVENUES**

SMALL GROUP INSURANCE MARKET REFORMS

- **GUARANTEED ISSUE AND RENEWABILITY**
 - *Insurers are required to offer coverage to all applicants regardless of health status*
 - *Insurers must renew coverage for all groups regardless of health status*
 - *Failure to pay premiums is the only grounds an insurer may use to terminate coverage*
- **ONCE A WORKER HAS SATISFIED PRE-EXISTING CONDITION REQUIREMENTS ON ONE PLAN, THOSE REQUIREMENTS ARE WAIVED IF THE INDIVIDUAL CHANGES JOBS OR THE EMPLOYER CHANGES INSURERS**
- **STATE MINIMUM BENEFITS LAWS ARE ELIMINATED TO PERMIT CREATION OF LOW COST INSURANCE PLANS**
- **PREMIUM SETTING LIMITATIONS**
 - *Premiums may not vary among groups by more than a specified percentage (e.g., 50 percent) of the average premium charged by the insurer for groups with similar age, sex, industry and geographic characteristics*
 - *Year-to-year premium increases for any group could not be more than a specified percentage (e.g., 15 percent) above the carriers general cost trend*
- **A REINSURANCE MECHANISM IS ESTABLISHED**
 - *Spreads risk for high risk groups across all insurers*
 - *Reinsurance funded by an assessment on all small group insurance policies*

MEDICAID EXPANSION

- ***ALL PERSONS BELOW POVERTY ARE COVERED UNDER MEDICAID REGARDLESS OF CATEGORICAL ELIGIBILITY STATUS***
- ***PROVIDER REIMBURSEMENT LEVELS ARE INCREASED TO LEVELS COMPARABLE TO THE MEDICARE PROGRAM***
- ***A UNIFORM NATIONWIDE MINIMUM STANDARD BENEFITS PACKAGE (SHOWN ON NEXT PAGE) IS ESTABLISHED (COMPARABLE TO THE MEDIAN BENEFITS PACKAGE CURRENTLY OFFERED BY THE STATES)***
- ***THE CURRENT FEDERAL/STATE MATCH IS USED FOR THE MEDICAID EXPANSION***

STANDARD MEDICAID BENEFITS PACKAGE

BENEFITS	PLAN PROVISIONS
<i>Inpatient Hospital Services</i>	<i>100%</i>
<i>Outpatient Hospital Services</i>	<i>100%</i>
<i>Rural Health Clinic Services</i>	<i>100%</i>
<i>Laboratory & X-ray Services</i>	<i>100%</i>
<i>Early and Periodic Screening, Diagnosis and Treatment Services for Individuals Under Age 21</i>	<i>100%</i>
<i>Physician Services</i>	<i>100%</i>
<i>Home Health Services</i>	<i>100%</i>
<i>Private Duty Nursing</i>	<i>100%</i>
<i>Preventive Dental Care</i>	<i>100%</i>
<i>Clinic Services</i>	<i>100%</i>
<i>Physical Therapy</i>	<i>100%</i>
<i>Occupational Therapy</i>	<i>100%</i>
<i>Speech, Hearing and Language Disorders</i>	<i>100%</i>
<i>Prosthetic Devices</i>	<i>100%</i>
<i>Diagnostic Tests</i>	<i>100%</i>
<i>Preventive Services</i>	<i>100%</i>
<i>Rehabilitative Services</i>	<i>100%</i>
<i>Case Management</i>	<i>100%</i>
<i>Podiatrist and Optometrist</i>	<i>100%</i>

MEDICAID BUY-IN

- ***A MEDICAID BUY-IN PROGRAM IS CREATED FOR PERSONS BETWEEN POVERTY AND 150 PERCENT OF POVERTY***
- ***COVERED SERVICES***
 - *Inpatient and outpatient hospital care*
 - *Physicians services*
 - *Prescription drugs*
 - *Laboratory and diagnostic tests*
 - *Mental health and substance abuse*
 - *Prenatal/well-baby/child care*
- ***COST SHARING***
 - *\$250 deductible (\$500 family)*
 - *80 percent coinsurance (50 percent mental health)*
 - *No cost sharing for prenatal and well child care*
 - *Out-of-pocket limit of \$3,000 per family*
- ***PREMIUMS PHASED-IN BETWEEN 100 AND 150 PERCENT OF PREMIUM***
 - *Individual premium of \$86*
 - *Family premium of \$172*
- ***THE CURRENT FEDERAL/STATE MEDICAID MATCH IS MAINTAINED FOR THE BUY-IN PROGRAM***

TABLE 1

**CHANGE IN THE NUMBER OF UNINSURED PERSONS
UNDER THE INSURANCE MARKET REFORM
PROPOSAL IN 1991
(In Thousands)**

	<i>Number Who Obtain Insurance</i>	<i>Reduction In Number Of Uninsured</i>	<i>Percent Of Uninsured</i>
<i>Extend Medicaid to Cover All Below Poverty</i>	12,158	5,834	18.3%
<i>Medicaid Buy-In Through 150 Percent of Poverty</i>	11,877	4,937	15.5
<i>Insurance Market Reform^{a/}</i>	921	515	1.6
<i>Eliminate State Mandated Benefits^{a/}</i>	2,314	1,214	3.8
<i>Increase Self-Employment Deduction^{a/}</i>	181	91	0.3
<i>Combined Impact</i>	27,451	12,591	39.6%

a Assumes each percentage reduction in premium costs is associated with a 0.4 percent increase in the number of employers offering insurance.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

TABLE 2

**CHANGE IN NATIONAL HEALTH SPENDING
UNDER THE INSURANCE MARKET REFORM
PROPOSAL IN 1991**
(In Billions)

Household Payments		\$19.2
Tax Payments	33.4	
Premium Payments	(3.0)	
Out-of-Pocket Spending	(11.2)	
Private Employers		(4.8)
Currently Provide Insurance	(5.9)	
Currently Do Not Insure	1.1	
State Governments (Program Fully Funded)^a		0.0
Federal Government (Program Fully Funded)^a		0.0
Local Governments		(3.0)
Change in National Health Spending		\$11.4
Utilization Increase for Newly Insured	6.9	
Net Increase in Provider Reimbursement ^b	4.2	
Net Change in Administrative Costs	0.3	

a We assume that state and federal governments raise the revenues needed to fully fund the program so that the proposal has no net impact on government spending.

b Increases in Medicaid reimbursement for hospital services are assumed to be passed-on to employers in the form of cost-shift savings. Increases in physician reimbursement are assumed to be retained as income.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 3

SOURCES AND USES OF FEDERAL FUNDS UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991
(In Billions)

Sources of Funds		Uses of Funds	
Personal Income Tax Increase ^a	\$19.5	Federal Share of Medicaid Expansion	\$20.2
		Tax Credit for Small Employer Costs Over 5 Percent of Revenues ^b	0.2
		Self Employed Deductions ^c	0.4
		Change in Corporate Tax Revenues ^d	(1.3)
Total Program Revenues	\$19.5	Total Program Costs	\$19.5

- ^a The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (5 percent).
^b Employers with 25 or fewer employees will receive a refundable tax credit for health expenditures in excess of 15 percent of revenues.
^c Self employed persons are permitted to deduct the full amount of their health benefit expenditures.
^d Employers are assumed to absorb changes in employer costs as changes in profits resulting in changes in corporate income tax deductions for health benefits and tax payments.

SOURCE: Lewin/ICF estimates using the Health Benefit Simulation Model (HBSM).

Table 4

**CHANGE IN MEDICAID PROGRAM COSTS FOR ACUTE CARE ONLY
UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991
(In Billions)^a**

	Total Program	Federal Cost	State Cost
Current Medicaid Program (Acute Care Only)	\$45.3	\$25.3	\$20.0
Offsets to Existing Program			
Cover Persons Up To Poverty Level	10.7	6.3	4.4
Minimum Benefits Standard	6.4	3.7	2.7
Improved Provider Reimbursement	12.6	7.4	5.2
Net Cost of Medicaid Buy-In Benefit Costs \$9.0 Premium Receipts (4.2)	4.8	2.8	2.0
Net Change in Medicaid Costs			
Net Change	\$34.5	\$20.2	\$14.3

^a Included benefits and administration for acute care only. Excludes long-term care.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 5

**SOURCES AND USES OF STATE FUNDS UNDER THE INSURANCE MARKET
REFORM PROPOSAL IN 1991**
(In Billions)

Sources of Funds		Uses of Funds	
Increase in State Taxes to Fund Program	\$13.9	State Share of Medicaid Expansion (see Table 4)	\$14.3
		State Corporate Income Taxes	(0.2)
		Savings to Indigent Care Programs	(0.2)
Total Sources of Funds	\$13.9	Total Uses of Funds	\$13.9

a Premium payments are subsidized for persons with incomes between the poverty line and 150 percent of poverty.

SOURCE: Lewin/ICF estimates using the Health Benefit Simulation Model (HBSM).

Table 6
IMPACT OF THE INSURANCE MARKET REFORM PROPOSAL ON PRIVATE EMPLOYERS
(In Billions, 1990)

	Firms That Now Offer Insurance	Firms That Do Not Insure	All Firms
Current Employer Expenditures for Health Insurance ^a	\$115.5	—	\$115.5
Changes in Employer Costs			
Cost of Insuring Workers and Dependents Not Now Covered	0.8	1.7	2.5
Tax Credit to Small Employers	0.0	(0.2)	(0.2)
Cost Shift Savings	(8.6)	—	(7.6)
Total Employer Costs	107.7	1.5	109.2
Net Change in Employer Cost	(7.8)	1.5	(6.3)
Change in Corporate Income Tax	1.9	(0.4)	1.5
Net After-Tax Change in Employer Costs	(5.9)	1.1	(4.8)

a Includes employer share of premium for workers, dependents, and retirees.

b The plan provides a refundable tax credit which limits employer expenditures for health benefits in small firms not to exceed 5 percent of revenues.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 7

**IMPACT OF THE INSURANCE MARKET REFORM
PROPOSAL ON HOUSEHOLD HEALTH RELATED
EXPENDITURES IN 1991**

(In Billions)

	Change From Current Policy
Funding for Public Program	
Premium Payments For Medicaid Buy-In	4.2
Federal Taxes^a	19.5
State Taxes^a	13.9
Offsets to Tax Payments	
Employee Share of Employer Plan Premiums	(2.4)
Non-Group Plan Premium Payments	(4.8)
Household Out-of-Pocket Expenditures	(11.2)
Total Net Change	\$19.2

a *New state and federal expenditures under the program are assumed to be fully funded through increases in personal taxes.*

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

THE UNIVERSAL MEDICAL EXPENSE PROPOSAL

Prepared For:

The Social Security Advisory Council

Prepared By:

***Lewin/ICF
A Health and Sciences International, Inc.***

December 19, 1991

THE UNIVERSAL MEDICAL EXPENSE PROPOSAL

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OVERVIEW OF PLAN

- **PROTECT ALL AMERICANS AGAINST THE COST OF CATASTROPHIC MEDICAL EXPENSES THROUGH THE CREATION OF THE UNIVERSAL MEDICAL EXPENSE PROTECTION PLAN (UMEPP).**
- **UMEPP WOULD OFFER MEDICARE BENEFITS AND PROVIDE STOP-LOSS PROTECTION TO MEDICARE AND MEDICAID BENEFICIARIES AND TO OTHER INDIVIDUALS AND FAMILIES NOT COVERED BY "QUALIFIED" EMPLOYER PLANS.**
- **UMEPP WOULD CERTIFY EMPLOYER PLANS AS "QUALIFIED" IF THEY MEET CERTAIN CRITERIA.**
- **LIMIT EMPLOYER TAX DEDUCTIONS FOR HEALTH INSURANCE TO QUALIFIED PLANS.**
- **INDIVIDUALS WOULD BE PERMITTED TO DEDUCT 50 PERCENT OF ANNUAL HEALTH INSURANCE PREMIUMS UP TO \$250.**
- **THE INDIVIDUAL TAX DEDUCTION FOR UNREIMBURSED MEDICAL EXPENSES WOULD BE REDUCED TO 2 PERCENT.**

UMEPP DEDUCTIBLES/CO-PAYMENTS AND STOP-LOSS

<i>If a Family's Income is:</i>	<i>The Deductible is:</i>	<i>Coinsurance is:</i>	<i>The Stop-Loss Limit is:</i>
<i>Below Federal Poverty Level* (\$13,400)</i>	<i>\$1,050</i>	<i>10%</i>	<i>\$1,750</i>
<i>Between 100% and 200% of the Federal poverty level (\$13,400 - 26,800)</i>	<i>\$1,050 plus 13 percent of income over Federal poverty level</i>	<i>15%</i>	<i>\$1,750 plus 15% of income over Federal poverty level</i>
<i>Over 200% of Federal poverty level (over \$26,800)</i>	<i>\$3,130 plus 20% of income over 200% of Federal poverty level</i>	<i>20%</i>	<i>\$4,150 plus 25% of income over 200% of Federal poverty level</i>

* The Federal poverty level is \$13,400 for a family of four in 1991.

EMPLOYER RESPONSIBILITY

- **EMPLOYER HEALTH INSURANCE PLANS MAY BE CONSIDERED QUALIFIED PLANS IF THEY INCLUDE:**
 - *No waiting period or exclusions for pre-existing conditions*
 - *Continuation of coverage*
 - *Annual open enrollment*
 - *Payment for the entire cost for services for which UMEPP would have covered*
 - *Employer premium contribution of 50 percent of the cost of the least expensive qualified plan*
- **ONLY QUALIFIED PLANS CAN RECEIVE A TAX DEDUCTION FOR THE COST OF HEALTH INSURANCE.**

PUBLIC RESPONSIBILITY

- **COVERAGE FOR THE UNINSURED**

- *UMEPP would cover the costs for all covered medical expenses above a deductible based on family income and all expenses above a stop-loss limit*

- **COVERAGE FOR MEDICARE BENEFICIARIES**

- *Medicare Part A deductibles would be repealed except for the initial inpatient hospital deductible. Part A coinsurance would be repealed.*
- *UMEPP will pay for all Medicare services after the stop-loss limit provided the individual has paid the deductible and cost-sharing requirements.*
- *Medicare Part A and Part B deductible and co-insurance payments count toward UMEPP's cost-sharing requirements.*

- **COVERAGE OF MEDICAID BENEFICIARIES**

- *UMEPP will pay for all Medicaid services after the stop-loss limit provided the individual has paid the deductible and cost-sharing requirements.*
- *States would be prohibited from reducing the amount, scope, or duration of Medicaid benefits, where the net effect is to shift costs onto UMEPP.*

- **COVERAGE OF PERSONS INSURED BY EMPLOYER PLANS**

- *If a plan results in greater cost-sharing than UMEPP, UMEPP would pay the difference up to the stop-loss amount.*

INDIVIDUAL RESPONSIBILITY

- **INDIVIDUALS WOULD BE RESPONSIBLE FOR PAYING FOR MEDICAL EXPENSES UP TO THE UMEPP STOP-LOSS LIMIT.**
- **NO INDIVIDUAL WOULD BE REQUIRED TO PAY DEDUCTIBLES AND COINSURANCE UNDER A QUALIFIED PLAN THAT RESULTS IN A GREATER COST TO THE INDIVIDUAL THAN UNDER UMEPP.**
- **IF AN EMPLOYEE FAILS TO ENROLL IN A QUALIFIED EMPLOYER PLAN, HE/SHE MAY PARTICIPATE IN UMEPP AFTER PAYMENT OF 1 1/2 TIMES THE UMEPP DEDUCTIBLE.**
- **INDIVIDUALS WOULD BE PERMITTED TO DEDUCT 50 PERCENT OF THE ANNUAL COST OF INSURANCE UP TO \$250.**
- **THE INDIVIDUAL TAX DEDUCTION FOR UNREIMBURSED MEDICAL EXPENSES WOULD BE REDUCED TO 2 PERCENT.**

TABLE 1

**CHANGE IN NATIONAL HEALTH SPENDING
UNDER THE UNIVERSAL MEDICAL EXPENSE
PROPOSAL IN 1991**
(In Billions)

<i>Household Payments</i>	9.0
<i>Tax Payments</i>	<i>\$43.1</i>
<i>Premium Payments</i>	<i>(8.3)</i>
<i>Out-of-Pocket Spending</i>	<i>(25.8)</i>
<i>Private Employers</i>	1.5
<i>State and Local Governments</i>	(6.0)
<i>Federal Government (Program Fully Funded)^a</i>	0.0
<i>Change in National Health Spending</i>	\$4.5
<i>Utilization Increase for Newly Insured</i>	<i>3.6</i>
<i>Net Change in Administrative Costs</i>	<i>0.9</i>

^a We assume that the federal government raises the revenues needed to fully fund the program so that the proposal has no net impact on government spending.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 2

**SOURCES AND USES OF FEDERAL FUNDS UNDER
THE UNIVERSAL MEDICAL EXPENSE PROPOSAL**

<i>Sources of Funds</i>		<i>Uses of Funds</i>	
Unspecified General Revenues ^a	\$51.2	Eliminate Medicare Part A Coinsurance ^b	\$ 5.7
		Catastrophic Coverage ^c - Medicare Recipients Other Individuals	15.3 20.5
		Administrative Cost ^d	1.1
		Tax Incentive to Enroll in Employer Plan ^e	3.9
		Net Change in Medical Expense Deduction ^f	4.2
		Change in Corporate Income Tax ^g	0.5
Total Sources of Funds		Total Uses of Funds	\$51.2

Footnotes to follow on next page

Footnotes to Table 2

- ^a We assume that the full amount of federal costs under the proposal will be funded by a proportional increase in personal income taxes (12.1 percent).*
- ^b The proposal eliminates Part B patient cost sharing.*
- ^c The catastrophic coverage program covers coinsurance and deductibles under Medicare and persons without private insurance. Catastrophic coverage also applies to Medicaid recipients but would involve minimal cost because Medicaid does not impose deductibles or coinsurance. Some costs would be incurred for Medicaid recipients in states with benefits limitations (inpatient days, etc.)*
- ^d Administrative costs are assumed to be equal to 2.7 percent of claims.*
- ^e The plan permits individuals to deduct half of the employee share of employer plan premiums up to \$250 as an incentive to participate in the employers plan. We assume that this deduction is provided over and above the exclusion of employee contributions for health insurance permitted under current law.*
- ^f The plan permits tax deductions for medical expenses in excess of two percent of AGI (deductions are currently limited to costs over 7.5 percent of AGI). The increase in deductions and subsequent tax loss would be offset by reductions in out-of-pocket spending resulting under the catastrophic coverage program.*
- ^g Employers are assumed to absorb the cost of expansions in coverage in the form of reduced profits resulting in changes in corporate income tax deductions for health benefits and tax payments.*

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

TABLE 3

**IMPACT OF THE UNIVERSAL MEDICAL EXPENSE
PROPOSAL ON PRIVATE EMPLOYERS IN 1991
(In Billions)**

<i>Current Employer Expenditures for Health Insurance</i>	<i>\$115.5</i>
<i>Changes in Employer Costs</i>	
<i>Workers and Dependents Induced to Take Employer Coverage</i>	<i>3.5</i>
<i>Minimum Benefit and Premium Standards</i>	<i>2.1</i>
<i>Cost Shift Savings</i>	<i>(3.5)</i>
<i>Net Change in Employer Costs</i>	<i>2.1</i>
<i>Change in Corporate Income Tax</i>	<i>(0.6)</i>
<i>Net After-Tax Change in Employer Costs</i>	<i>\$1.5</i>

^a *Includes employer share of premium for workers, dependents, and retirees.*

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

TABLE 4

**IMPACT OF THE UNIVERSAL MEDICAL EXPENDITURES
PROPOSAL ON STATE AND LOCAL GOVERNMENTS IN 1991
(In Billions)**

	<i>Change in Expenditures</i>
<i>Changes in Employee Benefit Costs</i>	<i>\$0.4</i>
<i>Savings to Public Hospitals and Other Programs^a</i>	<i>(6.6)</i>
<i>Loss of Corporate Income Taxes</i>	<i>0.2</i>
<i>Net Impact on State and Local Governments</i>	<i>(\$6.0)</i>

^a *Public hospitals that now serve indigent patients will be reimbursed for services provided to patients who become insured under the program resulting in savings to local governments.*

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

TABLE 5

**IMPACT OF THE UNIVERSAL MEDICAL EXPENDITURES
PROPOSAL ON HOUSEHOLD HEALTH EXPENDITURES IN 1991
(In Billions)**

	<i>Change from Current Policy</i>
<i>Federal Taxes</i>	<i>\$43.1</i>
<i>Tax Deduction for Employee Premiums</i> (3.9)	
<i>Change in Medical Expense Deduction</i> (4.2)	
<i>Federal Income Tax Payments</i> 51.2	
<i>Employee Share of Employer Plan Premiums</i>	<i>(1.2)</i>
<i>Non-Group Plan Premium Payments</i>	<i>(7.1)</i>
<i>Household Out-of-Pocket Expenditures</i>	<i>(25.8)</i>
<i>Total Net Change</i>	<i>\$9.0</i>

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

***THE INDIVIDUAL TAX CREDIT PROPOSAL:
ESTIMATED COST AND IMPACTS***

Prepared For:

The Social Security Advisory Council

Prepared By:

***Lewin/ICF
A Health and Sciences International, Inc.***

December 19, 1991

THE INDIVIDUAL TAX CREDIT PROPOSAL

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OVERVIEW OF PLAN

- **ALL PERSONS UNDER AGE 65 ARE REQUIRED TO PURCHASE INSURANCE.**
- **EMPLOYER BASED INSURANCE IS ELIMINATED. INSTEAD, EMPLOYER CONTRIBUTIONS FOR HEALTH BENEFITS ARE CONVERTED TO INCOME.**
- **MEDICAID IS ELIMINATED FOR ACUTE CARE. INSTEAD, A REFUNDABLE TAX CREDIT IS PROVIDED TO LOW INCOME PERSONS TO COVER THE COST OF INSURANCE.**
- **INDIVIDUALS MAY DEDUCT THE COST OF AN AVERAGE STANDARD INSURANCE PLAN IN DETERMINING PERSONAL INCOME TAXES. * PREMIUMS FOR BENEFITS IN EXCESS OF THE STANDARD PACKAGE ARE NOT TAX DEDUCTIBLE.**
- **THE PRIVATE INSURANCE MARKET WOULD BE REFORMED TO MAKE THE STANDARD BENEFITS PACKAGE AVAILABLE TO ALL.**
- **STATE MANDATED BENEFITS WOULD BE PREEMPTED AND RESTRICTIONS ON MANAGED CARE PLANS WOULD BE ELIMINATED.**

INDIVIDUAL RESPONSIBILITY

- **ALL PERSONS UNDER AGE 65 ARE REQUIRED TO PURCHASE INSURANCE**
- **MEDICARE IS RETAINED FOR PERSONS AGE 65 AND OLDER**
- **MEDICAID IS ELIMINATED FOR PERSONS UNDER AGE 65 FOR ACUTE CARE AND REPLACED WITH A REFUNDABLE TAX CREDIT. MEDICAID IS RETAINED FOR:**
 - **PERSONS AGE 65 AND OLDER**
 - **LONG-TERM CARE**
- **INDIVIDUALS MAY DEDUCT THE COST OF THE STANDARD BENEFITS PACKAGE IN DETERMINING PERSONAL INCOME TAXES**
- **INDIVIDUALS MAY PURCHASE SUPPLEMENTAL COVERAGE BUT PREMIUMS ARE NOT TAX DEDUCTIBLE**

BENEFITS PACKAGE

- **BASIC COVERAGE FOR ALL AMERICANS**

- \$250 deductible (\$500 per family)
- \$3,000 cost-sharing maximum

BENEFIT	COINSURANCE
<i>Inpatient Hospital Services (365-day per stay maximum)</i>	<i>80%</i>
<i>Outpatient Hospital Services</i>	<i>80%</i>
<i>Hospital Alternatives (extended or home health care)</i>	<i>Yes</i>
<i>Physician Services</i>	<i>75%</i>
<i>Prenatal/Well-Baby/Well-Child Care</i>	<i>75%</i>
<i>Diagnostic Tests</i>	<i>75%</i>
<i>Prescription Drugs</i>	<i>75%</i>
<i>Emergency Services</i>	<i>100%</i>
<i>Mental Health Care</i>	<i>Not Covered</i>
<i>Dental Care</i>	<i>Not Covered</i>

BENEFITS PACKAGE
(Continued)

• **COMPREHENSIVE COVERAGE FOR PERSONS
BELOW POVERTY.**

BENEFITS	PLAN PROVISIONS
<i>Rural Health Clinic Services</i>	100%
<i>Early and Periodic Screening, Diagnosis and Treatment Services for Individuals Under Age 21</i>	100%
<i>Home Health Services</i>	100%
<i>Private Duty Nursing</i>	100%
<i>Dental Care</i>	100%
<i>Clinic Services</i>	100%
<i>Physical Therapy</i>	100%
<i>Occupational Therapy</i>	100%
<i>Speech, Hearing and Language Disorders</i>	100%
<i>Dentures</i>	100%
<i>Prosthetic Devices</i>	100%
<i>Eyeglasses</i>	100%
<i>Preventive Services</i>	100%
<i>Rehabilitative Services</i>	100%
<i>Inpatient Psychiatric Care for Individuals Under Age 21</i>	100%
<i>Hospice Services</i>	100%
<i>Transportation</i>	100%
<i>Case Management</i>	100%
<i>Podiatrist, Optometrist, and Chiropractor Services</i>	100%

INSURANCE MARKET REFORMS

- **GUARANTEED ISSUE AND RENEWABILITY**
 - *Insurers are required to offer coverage to all applicants regardless of health status*
 - *Insurers must renew coverage for all groups regardless of health status*
 - *Failure to pay premiums is the only grounds an insurer may use to terminate coverage*
- **PRE-EXISTING CONDITION LIMITATIONS ARE ELIMINATED**
- **STATE MINIMUM BENEFITS LAWS ARE PREEMPTED**
- **PREMIUMS WILL BE SET ON A REGIONAL BASIS USING AN ADJUSTED COMMUNITY RATE**
 - *Age and sex premium variation permitted*
 - *Rates could not vary with medical history or condition*
- **A REINSURANCE MECHANISM IS ESTABLISHED**
 - *Spreads risk for high risk groups across all insurers*
 - *Reinsurance funded by an assessment on all small group insurance policies*

EMPLOYER RESPONSIBILITY

- ***EMPLOYERS WOULD NO LONGER PROVIDE HEALTH INSURANCE DIRECTLY TO EMPLOYEES***
- ***EMPLOYERS WOULD BE REQUIRED TO MAINTAIN THEIR CURRENT LEVEL OF EFFORT BY CONVERTING HEALTH BENEFIT PAYMENTS TO INCOME***
- ***EMPLOYERS WOULD SERVE THE ADMINISTRATIVE FUNCTION OF DEDUCTING PREMIUMS FROM WORKER PAYCHECKS AND SUBMITTING PAYMENTS TO INSURERS***

FEDERAL TAX CREDIT

- ***A REFUNDABLE TAX CREDIT IS ESTABLISHED TO COVER PREMIUMS AND COST SHARING UNDER THE STANDARD BENEFITS PACKAGE FOR PERSONS BELOW 200 PERCENT OF POVERTY***
- ***TAX CREDIT PHASED OUT BETWEEN 100 AND 200 PERCENT OF POVERTY***

<i>Income as a Percent of Poverty</i>	<i>Percent of Premiums and Cost Sharing Refunded</i>
<i><100</i>	<i>100%</i>
<i>101-110</i>	<i>90%</i>
<i>111-120</i>	<i>80%</i>
<i>121-130</i>	<i>70%</i>
<i>131-140</i>	<i>60%</i>
<i>141-150</i>	<i>50%</i>
<i>151-160</i>	<i>40%</i>
<i>161-170</i>	<i>30%</i>
<i>171-180</i>	<i>20%</i>
<i>181-190</i>	<i>10%</i>
<i>191-200</i>	<i>5%</i>
<i>200+</i>	<i>0%</i>

- ***MEDICAID IS ELIMINATED FOR ACUTE CARE***
 - *State and Federal funding used to fund the tax credit*
 - *Medicaid is maintained for long-term care*

FINANCING

- **STATE AND FEDERAL FUNDING FOR THE ACUTE CARE PORTION OF MEDICAID IS TRANSFERRED TO THE PUBLIC PROGRAM**
- **INCREASED TAX REVENUES DUE TO ELIMINATION OF TAX DEDUCTIONS FOR BENEFITS IN EXCESS OF THE FEDERAL STANDARD**
- **ANY ADDITIONAL FEDERAL FUNDING REQUIREMENTS ARE ASSUMED TO BE FINANCED BY AN ACROSS THE BOARD INCREASE IN FEDERAL PERSONAL INCOME TAXES**
 - *Personal income tax increase: \$24.0 billion*
 - *Personal income tax rates are increased by 4.9 percent*

COST CONTAINMENT

- ***STATE LAWS IMPEDING SELECTIVE CONTRACTING, UTILIZATION REVIEW AND OTHER MANAGED CARE MECHANISMS ARE ELIMINATED***
- ***ELIMINATION OF TAX BENEFITS FOR COVERAGE IN EXCESS OF THE FEDERAL STANDARD WILL ENCOURAGE INDIVIDUALS TO REDUCE HEALTH CARE CONSUMPTION***

ASSUMPTION

- ***ALL INDIVIDUALS IN PLANS WHICH EXCEED THE MINIMUM BENEFITS STANDARDS ARE ASSUMED TO SHIFT TO SOME FORM OF MANAGED CARE PLAN IN WHICH HEALTH SPENDING IS REDUCED TO THE POINT WHERE THE EMPLOYEE AFTER TAX PREMIUM CONTRIBUTION IS THE SAME AS UNDER CURRENT POLICY***

Table 1

**CHANGE IN NATIONAL HEALTH SPENDING
UNDER THE INDIVIDUAL TAX CREDIT MODEL IN 1991
(In Billions)**

Household Payments		\$ 20.3
Private Employers		0.0
Employer Insurance Payments	(105.7)	
Employer FICA Taxes	2.7	
Employee Wages and Salaries	103.0	
State and Local Governments		(18.8)
Federal Government (Program Fully Funded)		0.0
Change in National Health Spending		\$(1.5)
Utilization Increase for Newly Insured	12.2	
Net Increase in Provider Reimbursement	4.2	
Tax Induced Reduction in Utilization	(20.8)	
Net Change in Administrative Costs	2.9	

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

Table 2

**SOURCES AND USES OF FEDERAL FUNDS UNDER
THE INDIVIDUAL TAX CREDIT PROPOSAL IN 1991**
(In Billions)

Sources of Funds		Uses of Fund	
Taxes on Benefits Converted to Income ^a Personal Income Taxes OASDI and HI Payroll Taxes	12.9 5.5	Tax Credit ^d	\$67.1
		Premium Subsidy	52.4
		Cost Sharing Subsidy	14.7
		Administrative Costs	1.1
State Contribution to Public Plan ^b		Net Change in Tax Revenues Due to Tax Deduction for Federal Benefit Standard ^c	8.1
Personal Income Tax Increase ^e		Offsets to Medicaid ^f	(16.8)
		Elimination of Health Care Deduction ^g	(4.2)
TOTAL SOURCES OF FUNDS		TOTAL USES OF FUNDS	\$55.3

Table 2

**SOURCES AND USES OF FEDERAL FUNDS UNDER
THE INDIVIDUAL TAX CREDIT PROPOSAL IN 1991
(Cont.)**

- a* Employer contributions to health benefits are converted to wages and salaries resulting in an increase in OASDI and HI payroll tax payments.
- b* States are assumed to transfer to the program all funds currently used to finance the state share of Medicaid spending for acute care for persons under age 65. Medicaid is assumed to be retained for long-term care.
- c* The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (4.8 percent).
- d* A refundable tax credit is provided to subsidize premium payments and cost sharing for low income persons.
- e* A tax credit is provided for purchase of the Federal standard benefits package.
- f* Medicaid is eliminated for acute care for persons under age 65 resulting in savings to the Federal government.
- g* The current deduction for health benefits expenses in excess of 7.5 percent of adjusted gross income is eliminated.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 3

**CHANGE IN PRIVATE EMPLOYER SPENDING
UNDER THE INDIVIDUAL TAX CREDIT MODEL IN 1991
(In Billions)**

<i>Current Employer Expenditures for Health Care</i>	<i>\$115.5</i>
<i>Coverage Eliminated for Persons Under Age 65</i>	<i>(105.7)</i>
<i>Employer Contribution Converted To Wages^a</i>	<i>103.0</i>
<i>OASDI and HI Tax on Wages</i>	<i>2.7</i>
<i>Net Change in Employer Costs</i>	<i>0.0</i>

a *Employers are assumed to convert their contribution for health benefits to wages and salaries adjusted for increases in employer OASDI and HI tax payments on these wages and salaries.*

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

Table 4

**IMPACT OF THE INDIVIDUAL TAX CREDIT MODEL ON
STATE AND LOCAL GOVERNMENTS IN 1991
(In Billions)**

Table 5

**CHANGE IN HOUSEHOLD HEALTH SPENDING UNDER
THE INDIVIDUAL TAX CREDIT MODEL IN 1991
(In Billions)**

NEW EXPENDITURES UNDER PROGRAM	
<i>Individual Premium Payments for Insurance</i>	\$206.4
<i>Estimated Purchase of Supplemental Coverage</i>	39.6
<i>Federal Personal Income Tax Increase to Fund Tax Credit Program</i>	24.0
<i>Increase in State Personal Income Taxes</i>	2.3
OFFSETS TO HOUSEHOLD SPENDING	
<i>Net Increase in Disposable Income^a</i>	(110.0)
<i>Premium Subsidy to Low Income Persons</i>	(52.4)
<i>Cost Sharing Subsidy to Low Income Persons</i>	(14.7)
<i>Premium Payments for Non-Group Coverage</i>	(15.8)
<i>Employee Share of Premium Payments</i>	(43.3)
<i>Out of Pocket Expenses</i>	(15.8)
<i>Net Change in Household Spending</i>	\$20.3

a Change in personal income less changes in tax payments for that income under the proposal.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

ALTERNATIVE TAX CREDIT OPTIONS

Presented To:

The Social Security Advisory Council

Presented By:

Lewin/ICF
a division of Health & Sciences International

December 19, 1991

TAX CREDIT PROPOSAL

- ALL INDIVIDUALS UNDER AGE 65 ARE REQUIRED TO PURCHASE INSURANCE
- MEDICARE IS RETAINED FOR PERSONS UNDER AGE 65 FOR ACUTE CARE AND REPLACED WITH A REFUNDABLE TAX CREDIT. MEDICAID IS RETAINED FOR:
 - Persons age 65 and older
 - Long-term care
- INDIVIDUALS RECEIVE A TAX CREDIT FOR THE COST OF A BASIC HEALTH INSURANCE PACKAGE
- EXISTING HEALTH TAX EXPENDITURES ELIMINATED (\$63.7 BILLION)
 - Employer health benefits exclusion: \$59.4 billion
 - Tax deduction for health expenses: \$4.3 billion

INSURANCE RATING UNDER TAX CREDIT PLAN

- ASSUMED PREMIUM VARIATION BY AGE, SEX, HEALTH STATUS AND REGION
- PREMIUM VARIATION AS A PERCENT OF STANDARD RISK

REGIONAL VARIATION		HEALTH STATUS VARIATION
Northeast	95.0%	Poor Health 240.2%
Midwest	104.8	Fair Health 150.4
South	92.7	Good Health 99.2
West	108.9%	Excellent Health 89.3

AGE VARIATION		SEX VARIATION	
Less Than 18	37.3%	Male	89.9%
18-24	70.5	Female	108.9%
25-34	74.0		
35-44	64.7		
45-54	82.3		
55-64	131.7%		

TAX CREDIT AMOUNTS

- MAXIMUM TAX CREDIT VARIES BY AGE BASED UPON COST OF BASIC HEALTH PLAN FOR LOW-INCOME PERSONS

Age of Individual	Annual Tax Credit Amount at or Below Poverty
Less Than 18	\$ 677
18-24	1,281
25-34	1,344
35-44	1,176
45-54	1,496
55-64	2,393
Average Annual	\$1,817

- ADD-ON TO TAX CREDIT FOR HIGH RISK INDIVIDUALS (PREMIUMS OVER 150 PERCENT OF STANDARD RISK)

-- Option A: \$1,000
 -- Option B: \$2,000
 -- Option C: \$5,000

- TAX CREDIT PHASED OUT FOR INCOMES ABOVE POVERTY WITH FULL PHASE-OUT AT

-- Option 1: 200 percent of poverty
 -- Option 2: 300 percent of poverty
 -- Option 3: 400 percent of poverty
 -- Option 4: 600 percent of poverty

TAX CREDIT IMPACTS

- TAX CREDIT EXPENDITURE (IN BILLIONS)

	HIGH RISK ADD-ON	
	\$1,000	\$2,000
Income Phase-Out Amount	\$5,000	\$5,000
200 Percent of Poverty	\$35.5	\$39.1
300 Percent of Poverty	51.4	56.0
400 Percent of Poverty	66.8	71.8
600 Percent of Poverty	\$90.4	\$95.6
		\$102.4

- NET CHANGE IN TAX EXPENDITURE (IN BILLIONS)

	HIGH RISK ADD-ON	
	\$1,000	\$2,000
Income Phase-Out Amount	\$5,000	\$5,000
200 Percent of Poverty	\$(28.2)	\$(24.6)
300 Percent of Poverty	(12.3)	(7.7)
400 Percent of Poverty	3.1	8.1
600 Percent of Poverty	\$26.7	\$31.9
		\$ 38.7

TABLE 1-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 200% POVERTY: HIGH RISK ADD-ON OF \$1000

	REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS					
	FAMILIES (THOUS)	1000+	500- 999	250- 499	100- 249	1- 99	NO CHANGE	1- 99	100- 249	250- 499	500- 999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.7	26.9	47.9
10,000-14,999	5541.	0.2	1.3	5.4	4.2	7.4	1.6	4.7	5.4	16.2	15.0	36.7
15,000-19,999	6602.	1.8	8.6	24.4	6.8	6.6	9.6	1.6	1.9	5.7	8.3	24.7
20,000-29,999	10400.	9.3	21.0	28.2	4.3	7.3	9.6	1.0	1.4	3.2	4.4	10.3
30,000-39,999	9901.	29.9	33.1	13.4	3.7	10.1	5.4	0.6	0.5	0.7	1.3	1.3
40,000-49,999	8529.	35.8	36.5	12.2	2.1	8.9	3.7	0.2	0.0	0.0	0.3	0.3
50,000-74,999	15034.	57.7	22.5	7.6	1.3	6.5	4.2	0.1	0.1	0.0	0.1	0.0
75,000 +	10648.	62.3	20.2	4.6	0.2	8.7	4.1	0.0	0.0	0.0	0.0	0.0
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 145%	6156.	0.2	1.1	1.0	1.3	1.3	0.2	2.6	3.7	15.4	20.7	52.6
150% - 199%	6405.	3.8	9.2	7.9	6.6	5.2	0.0	6.1	8.0	19.3	16.6	17.4
200% - 299%	13198.	26.6	23.8	20.2	5.3	11.6	10.6	0.4	0.3	0.2	1.0	0.0
300% +	41458.	45.0	26.4	13.5	1.7	8.0	5.4	0.0	0.0	0.0	0.0	0.0
TOTAL	78309.	28.6	18.9	11.3	2.5	6.8	4.6	0.9	1.4	4.9	6.6	13.5

TABLE 2-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY: HIGH RISK ADD-ON OF \$1000

	FAMILIES RECEIVING TAX BENEFITS TODAY												DO NOT NOW GET TAX BENEFIT	
	ALL FAMILIES						LOSERS							
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT		
FAMILY INCOME														
	< 10,000	11653.	57.52	1449.73	4263.	125.46	1293.29	152.	889.40	539.87	7238.	1561.09		
	10,000-14,999	5541.	182.85	1371.19	3279.	235.23	1334.33	373.	649.25	442.73	1890.	1618.34		
	15,000-19,999	6602.	321.59	1168.41	3717.	317.82	1298.12	1330.	708.00	438.18	1555.	1483.23		
	20,000-29,999	10400.	527.12	819.04	3625.	582.23	1759.13	5438.	620.00	198.68	1337.	793.62		
	30,000-39,999	9901.	813.46	477.09	1956.	652.71	1543.68	7347.	922.54	190.63	598.	507.16		
	40,000-49,999	8529.	874.71	236.02	973.	715.75	1410.73	7226.	935.94	64.83	329.	520.39		
	50,000-74,999	15034.	1173.81	41.86	231.	765.36	1839.16	14177.	1232.27	14.09	626.	6.22		
	75,000 +	10648.	1257.44	2.01	0.	0.00	0.00	10216.	1310.70	2.09	433.	0.00		
INC AS % OF POV														
	< POVERTY	11080.	65.68	1679.14	4181.	144.05	1654.89	132.	953.37	603.02	6768.	1715.10		
	100% - 149%	6156.	250.66	1616.60	3638.	320.54	1697.88	301.	1253.60	958.57	2218.	1572.64		
	150% - 199%	6405.	491.56	1412.88	4458.	522.77	1497.12	646.	1266.96	809.53	1301.	1423.77		
	200% - 299%	13198.	687.80	774.21	5646.	461.11	1068.42	6059.	1068.65	487.87	1493.	824.11		
300% +	41458.	997.18	6.90	123.	380.79	875.97	39112.	1055.80	3.94	2224.	10.91			
TOTAL	78309.	713.07	614.38	18045.	374.00	1435.81	46259.	1061.23	86.48	14004.	1299.77			

TABLE 2-8
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY: HIGH RISK ADD-ON OF \$1000

	FAMILIES (THOUS)	REDUCTION IN TAX BENEFITS					INCREASE IN TAX BENEFITS					
		1000+	500- 999	250- 499	100- 249	1- 99	NO CHANGE	1- 99	100- 249	250- 499	500- 999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	18.5	23.9	41.0
15,000-19,999	6602.	0.7	2.1	4.2	7.6	5.3	0.6	8.3	9.8	14.2	12.3	34.8
20,000-29,999	10400.	2.1	12.2	26.5	6.8	4.8	5.1	2.8	4.2	5.6	9.6	20.4
30,000-39,999	9901.	17.3	28.2	16.5	4.3	7.8	3.6	1.6	2.6	4.0	5.5	8.4
40,000-49,999	8529.	29.1	33.3	12.4	2.9	6.9	2.9	0.6	2.5	2.2	3.3	3.8
50,000-74,999	15034.	56.3	23.0	7.6	1.3	6.1	4.1	0.1	0.4	0.3	0.2	0.7
75,000 +	10648.	62.3	20.2	4.6	0.2	8.7	4.1	0.0	0.0	0.0	0.0	0.0
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.3	1.5	0.2	2.1	4.2	15.2	18.6	54.8
150% - 199%	6405.	1.1	1.9	1.9	2.0	2.8	0.3	5.7	6.2	16.3	25.5	36.2
200% - 299%	13198.	6.9	12.4	12.0	9.3	5.1	0.3	6.7	10.4	12.4	11.7	12.7
300% +	41458.	44.8	26.3	13.6	1.7	8.0	5.3	0.0	0.0	0.2	0.2	0.0
TOTAL	78309.	25.0	16.3	9.5	2.8	5.5	2.9	1.9	3.0	6.8	9.0	17.4

TABLE 3-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65
INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF \$1000

FAMILY INCOME	FAMILIES RECEIVING TAX BENEFITS TODAY										DO NOT NOW GET TAX BENEFIT	
	ALL FAMILIES					WINNERS					LOSERS	
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT
< 10,000	11653.	57.52	1451.81	4263.	125.46	1295.90	152.	889.40	539.87	7238.	1562.90	
10,000-14,999	5541.	182.85	1401.41	3279.	235.23	1382.48	373.	649.25	445.68	1890.	1657.54	
15,000-19,999	6602.	321.59	1290.56	4312.	331.01	1294.22	735.	946.47	622.57	1555.	1596.42	
20,000-29,999	10400.	527.12	1120.73	5734.	549.47	1516.99	3330.	700.31	423.82	1337.	1157.35	
30,000-39,999	9901.	813.46	881.88	3785.	687.21	1561.65	5518.	988.33	419.27	598.	848.71	
40,000-49,999	8529.	874.71	612.05	2276.	733.41	1599.08	5924.	977.59	224.43	329.	764.43	
50,000-74,999	15034.	1173.81	234.51	1122.	747.58	1575.83	13287.	1265.07	127.96	626.	91.74	
75,000 +	10648.	1257.44	18.51	66.	1255.53	1549.97	10150.	1311.05	8.60	433.	17.86	
INC AS % OF POV												
< POVERTY	11080.	65.68	1679.14	4181.	144.05	1654.89	132.	953.37	603.02	6768.	1715.10	
100% - 149%	6156.	250.66	1645.70	3638.	320.54	1726.13	301.	1253.60	966.95	2218.	1605.92	
150% - 199%	6405.	491.56	1473.90	4481.	528.54	1556.32	623.	1252.51	789.69	1301.	1517.79	
200% - 299%	13198.	687.80	1279.20	8983.	585.59	1380.39	2722.	1402.65	980.32	1493.	1215.64	
300% +	41458.	997.18	180.28	3554.	472.29	877.56	35682.	1111.56	112.58	2224.	152.21	
TOTAL	78309.	713.07	798.56	24836.	445.94	1437.04	39468.	1134.21	191.23	14004.	1377.97	

TABLE 3-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF \$1000

	FAMILIES (THOUS.)	REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS					
		1000+	500- 999	250- 499	100- 249	1- 99	NO CHANGE	1- 99	100- 249	250- 499	500- 999	1000+	
FAMILY INCOME													
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5	
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	17.5	23.2	42.7	
15,000-19,999	6602.	0.3	2.4	2.1	2.4	4.0	0.0	7.0	11.1	18.6	15.1	37.1	
20,000-29,999	10400.	0.1	4.9	9.5	8.8	8.5	0.5	9.8	7.5	11.6	13.2	25.6	
30,000-39,999	9901.	7.3	19.7	15.8	6.7	6.3	2.7	3.2	5.7	5.7	12.6	14.3	
40,000-49,999	8529.	16.8	28.3	12.9	4.6	6.8	2.7	2.3	3.5	5.4	6.4	10.3	
50,000-74,999	15034.	48.2	22.5	9.5	2.5	5.7	3.6	0.4	1.5	2.0	1.8	2.3	
75,000 +	10648.	61.5	20.2	4.7	0.2	8.7	4.0	0.2	0.3	0.0	0.2	0.0	
INC. AS % OF POV													
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3	
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.7	0.2	2.1	4.0	15.5	18.6	54.8	
150% - 199%	6405.	0.9	2.1	1.8	2.2	2.4	0.3	5.8	6.1	15.2	24.0	39.2	
200% - 299%	13198.	2.1	3.7	4.4	4.6	5.9	0.0	7.8	10.7	16.1	19.8	25.0	
300% +	41458.	37.7	24.0	12.2	4.2	7.9	3.7	2.1	2.4	2.9	2.1	0.8	
TOTAL	78309.	20.4	13.6	7.4	3.4	5.6	2.0	3.2	4.3	8.8	11.3	20.1	

TABLE 4--A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65
INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF \$1000

	FAMILIES RECEIVING TAX BENEFITS TODAY												DO NOT NOW GET TAX BENEFIT	
	ALL FAMILIES						LOSERS							
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME														
< 10,000	11653.	57.52	1453.47	4263.	125.46	1297.98	152.	889.40	539.87	7238.	1564.35			
10,000-14,999	5541.	182.85	1425.13	3279.	235.23	1384.32	373.	649.25	448.03	1890.	1688.74			
15,000-19,999	6602.	321.59	1340.76	4326.	332.40	1343.79	721.	950.49	627.94	1555.	1662.90			
20,000-29,999	10400.	527.12	1302.55	7061.	541.10	1481.98	2003.	829.76	620.99	1337.	1376.28			
30,000-39,999	9901.	813.46	1313.41	6083.	698.11	1606.23	3220.	1182.65	772.42	598.	1248.75			
40,000-49,999	8529.	874.71	1156.65	4444.	753.78	1627.24	3756.	1094.47	587.29	329.	1301.60			
50,000-74,999	15034.	1173.81	808.11	4237.	881.70	1709.10	10171.	1367.72	452.24	626.	492.24			
75,000 +	10648.	1257.44	255.49	756.	907.38	1778.91	9460.	1342.92	135.91	433.	209.76			
INC AS % OF POV														
< POVERTY	11080.	65.68	1679.14	4181.	144.05	1654.89	132.	953.37	603.02	6768.	1715.10			
100% - 149%	6156.	250.66	1668.97	3650.	331.09	1754.67	288.	1159.99	865.37	2218.	1632.54			
150% - 199%	6405.	491.56	1518.15	4481.	528.54	1598.48	623.	1252.51	793.93	1301.	1588.37			
200% - 299%	13198.	687.80	1441.13	9349.	622.79	1577.35	2356.	1381.93	946.89	1493.	1368.36			
300% +	41458.	997.18	659.63	12768.	670.93	1306.24	26453.	1238.50	357.96	2224.	528.04			
TOTAL	78309.	713.07	1085.08	34448.	539.43	1507.69	29856.	1247.96	419.49	14004.	1464.73			

TABLE 4-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF \$1000

	FAMILIES (THOUS)	REDUCTION IN TAX BENEFITS					INCREASE IN TAX BENEFITS					
		1000+	500- 999	250- 499	100- 249	1- 99	NO CHANGE	1- 99	100- 249	250- 499	500- 999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	17.0	22.0	44.3
15,000-19,999	6602.	0.3	2.4	2.1	2.3	3.9	0.0	5.8	8.6	20.2	16.6	37.9
20,000-29,999	10400.	0.1	1.9	3.0	6.0	8.2	0.0	9.7	8.0	16.4	17.2	29.4
30,000-39,999	9901.	3.1	5.0	8.4	10.2	6.0	0.1	5.1	9.3	11.7	17.8	23.5
40,000-49,999	8529.	3.8	13.0	16.2	6.4	4.7	0.7	4.2	7.2	9.2	15.8	18.9
50,000-74,999	15034.	27.0	19.7	11.7	5.1	4.3	1.7	2.4	4.5	5.7	8.8	9.3
75,000 +	10648.	53.0	21.1	4.9	1.7	8.1	3.6	0.2	1.0	2.0	1.8	2.5
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.5	0.2	2.3	4.0	15.3	18.2	55.4
150% - 199%	6405.	0.9	2.1	1.8	2.0	2.6	0.3	5.8	5.9	14.8	23.5	40.3
200% - 299%	13198.	2.0	3.3	3.8	4.5	4.3	0.1	6.2	8.9	16.4	19.4	31.1
300% +	41458.	24.2	15.9	10.4	6.1	7.2	1.7	3.9	5.6	8.4	9.5	7.1
TOTAL	78309.	13.2	9.3	6.4	4.3	4.9	1.0	3.9	5.6	11.7	15.1	24.6

TABLE 5-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 200% POVERTY: HIGH RISK ADD-ON OF \$2000

	FAMILIES RECEIVING TAX BENEFITS TODAY										DO NOT NOW GET TAX BENEFIT	
	ALL FAMILIES					LOSERS						
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)		AVG TAX CREDIT
FAMILY INCOME												
< 10,000	11653.	57.52	1578.47	4263.	125.46	1367.33	152.	889.40	539.87	7238.	1724.74	
10,000-14,999	5541.	182.85	1262.97	2633.	211.75	1481.33	1019.	447.27	235.85	1890.	1512.80	
15,000-19,999	6602.	321.59	819.70	1883.	315.45	1789.17	3164.	463.23	92.77	1555.	1125.36	
20,000-29,999	10400.	527.12	443.35	1904.	560.02	1923.13	7159.	616.82	61.70	1337.	379.80	
30,000-39,999	9901.	813.46	103.12	421.	683.85	1665.13	8882.	874.39	22.32	598.	204.76	
40,000-49,999	8529.	874.71	28.38	84.	948.77	1588.10	8116.	909.39	9.86	329.	87.99	
50,000-74,999	15034.	1173.81	5.67	39.	797.01	1609.45	14370.	1225.92	1.59	626.	0.00	
75,000 +	10648.	1257.44	0.00	0.	0.00	0.00	10216.	1310.70	0.00	433.	0.00	
INC AS % OF POV												
< POVERTY	11080.	65.68	1822.93	4181.	144.05	1754.69	132.	953.37	603.02	6768.	1888.86	
100% - 149%	6156.	250.66	1620.72	3650.	331.09	1696.02	288.	1159.99	844.52	2218.	1597.85	
150% - 199%	6405.	491.56	889.18	3013.	383.32	1188.53	2090.	953.64	403.90	1301.	975.55	
200% - 299%	13198.	687.80	63.10	357.	497.53	1490.40	11348.	784.31	13.63	1493.	97.57	
300% +	41458.	997.18	1.45	24.	283.95	566.26	39211.	1054.15	0.95	2224.	4.22	
TOTAL	78309.	713.07	469.47	11225.	280.65	1572.72	53079.	992.66	25.60	14004.	1267.54	

TABLE 5-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 200% POVERTY: HIGH RISK ADD-ON OF \$2000

	FAMILIES (THOUS)	REDUCTION IN TAX BENEFITS					INCREASE IN TAX BENEFITS						
		1000+	500- 999	250- 499	100- 249	1- 99	NO CHANGE	1- 99	100- 249	250- 499	500- 999	1000+	
FAMILY INCOME													
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.7	26.9	47.9	
10,000-14,999	5541.	0.2	1.3	5.4	4.2	7.4	1.6	4.7	5.4	16.2	14.7	39.0	
15,000-19,999	6602.	1.8	8.6	24.4	6.5	6.6	9.6	1.6	1.7	5.7	8.1	25.5	
20,000-29,999	10400.	8.7	20.5	27.7	4.4	7.5	9.4	0.8	1.3	3.4	4.7	11.6	
30,000-39,999	9901.	29.6	32.6	13.1	4.2	10.2	5.2	0.5	0.5	0.7	1.3	2.2	
40,000-49,999	8529.	35.6	36.4	12.2	2.1	8.9	3.7	0.3	0.0	0.2	0.4	0.3	
50,000-74,999	15034.	57.7	22.4	7.6	1.4	6.5	4.2	0.1	0.0	0.0	0.1	0.1	
75,000 +	10648.	62.3	20.2	4.6	0.2	8.7	4.1	0.0	0.0	0.0	0.0	0.0	
INC AS % OF POV													
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3	
100% - 149%	6156.	0.2	1.1	0.8	1.3	1.3	0.2	2.6	3.7	15.4	20.9	52.6	
150% - 199%	6405.	3.6	9.2	7.9	6.6	5.4	0.0	6.1	7.8	19.1	16.5	17.9	
200% - 299%	13198.	25.9	23.4	19.6	5.3	11.8	10.4	0.2	0.2	0.4	0.9	2.0	
300% +	41458.	45.0	26.3	13.5	1.8	8.0	5.3	0.0	0.0	0.0	0.0	0.0	
TOTAL	78309.	28.5	18.7	11.2	2.6	6.8	4.6	0.9	1.3	5.0	6.6	13.9	

TABLE 6-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY: HIGH RISK ADD-ON OF \$2000

FAMILY INCOME	FAMILIES RECEIVING TAX BENEFITS TODAY										DO NOT NOW GET TAX BENEFIT				
	ALL FAMILIES					WINNERS							LOSERS		
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT
< 10,000	11653.	57.52	1584.52	4263.	125.46	1375.14	152.	889.40	539.87	7238.	1729.88				
10,000-14,999	5541.	182.85	1449.48	3279.	235.23	1402.66	373.	649.25	442.73	1890.	1729.35				
15,000-19,999	6602.	321.59	1241.37	3717.	317.82	1376.59	1330.	708.00	438.18	1555.	1605.44				
20,000-29,999	10400.	527.12	877.40	3637.	591.93	1890.62	5426.	613.58	191.63	1337.	904.06				
30,000-39,999	9901.	813.46	530.25	2066.	669.98	1686.93	7237.	921.70	192.44	598.	621.86				
40,000-49,999	8529.	874.71	262.91	1035.	713.93	1519.57	7165.	938.11	69.48	329.	520.39				
50,000-74,999	15034.	1173.81	61.90	345.	785.03	1864.46	14063.	1235.57	19.25	626.	25.52				
75,000 +	10648.	1257.44	9.38	34.	653.48	826.41	10182.	1312.88	7.07	433.	0.00				
INC AS % OF POV															
< POVERTY	11080.	65.68	1822.93	4181.	144.05	1754.69	132.	953.37	603.02	6768.	1888.86				
100% - 149%	6156.	250.66	1710.81	3650.	331.09	1785.65	288.	1159.99	858.52	2216.	1698.57				
150% - 199%	6405.	491.56	1494.40	4458.	522.77	1569.39	646.	1266.96	809.53	1301.	1577.37				
200% - 299%	13198.	687.80	832.99	5657.	463.56	1179.14	6048.	1067.45	486.44	1493.	925.73				
300% +	41458.	997.18	25.18	432.	680.77	1541.74	38804.	1057.83	8.02	2224.	30.22				
TOTAL	78309.	713.07	668.38	18377.	384.02	1533.75	45927.	1062.18	89.33	14004.	1431.86				

TABLE 6-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY: HIGH RISK ADD-ON OF \$2000

	FAMILIES (THOUS)	REDUCTION IN TAX BENEFITS					INCREASE IN TAX BENEFITS						
		1000+	500- 999	250- 499	100- 249	1- 99	NO CHANGE	1- 99	100- 249	250- 499	500- 999	1000+	
FAMILY INCOME													
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5	
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	18.5	23.9	41.0	
15,000-19,999	6602.	0.7	2.1	4.2	7.6	5.3	0.6	8.3	9.8	14.2	12.3	34.8	
20,000-29,999	10400.	2.1	12.2	26.5	6.7	4.8	5.1	2.8	4.1	5.4	9.2	21.3	
30,000-39,999	9901.	16.9	28.1	16.1	4.1	7.8	3.6	1.6	2.7	3.4	6.2	9.4	
40,000-49,999	8529.	28.6	33.0	12.4	2.9	7.1	2.9	0.7	2.2	2.2	2.9	5.0	
50,000-74,999	15034.	55.8	23.1	7.5	1.2	6.0	4.1	0.0	0.6	0.3	0.5	1.0	
75,000 +	10648.	61.9	20.4	4.4	0.2	8.7	4.1	0.2	0.0	0.2	0.0	0.0	
INC AS % OF POV													
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3	
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.5	0.2	2.1	4.2	15.2	18.8	54.8	
150% - 199%	6405.	1.1	1.9	1.9	2.0	2.8	0.3	5.7	6.2	16.2	25.5	36.3	
200% - 299%	13198.	6.9	12.4	12.0	9.3	5.1	0.3	6.7	10.0	12.2	11.2	13.9	
300% +	41458.	44.3	26.3	13.5	1.6	8.0	5.3	0.1	0.1	0.1	0.4	0.4	
TOTAL	78309.	24.7	16.3	9.4	2.7	5.5	2.9	1.9	3.0	6.7	9.1	17.8	

TABLE 7-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF \$2000

FAMILY INCOME	FAMILIES RECEIVING TAX BENEFITS TODAY										DO NOT NOW GET TAX BENEFIT				
	ALL FAMILIES					WINNERS							LOSERS		
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT	
< 10,000	11653	57.52	1586.49	4263	125.46	1377.75	152	889.40	539.87	7238	1731.52				
10,000-14,999	5541	182.85	1479.62	3279	235.23	1430.66	373	649.25	445.68	1890	1768.56				
15,000-19,999	6602	321.59	1363.27	4312	331.01	1361.57	735	946.47	622.57	1555	1718.37				
20,000-29,999	10400	527.12	1178.99	5746	555.69	1600.80	3317	690.11	412.70	1337	1267.79				
30,000-39,999	9901	813.46	937.16	3815	695.50	1681.00	5489	984.22	417.25	598	963.41				
40,000-49,999	8529	874.71	643.44	2319	741.26	1692.36	5681	976.28	223.09	329	764.43				
50,000-74,999	15034	1173.81	263.71	1226	750.21	1688.27	13182	1268.93	138.11	626	117.37				
75,000 +	10648	1257.44	39.95	163	1020.89	1560.01	10053	1315.39	16.29	433	17.86				
INC AS % OF POV															
< POVERTY	11080	65.68	1822.93	4181	144.05	1754.69	132	953.37	603.02	6768	1808.86				
100% - 149%	6156	250.66	1739.24	3650	331.09	1813.40	286	1159.99	862.34	2218	1731.32				
150% - 199%	6405	491.56	1555.35	4481	528.54	1628.22	623	1252.51	789.69	1301	1671.07				
200% - 299%	13198	667.80	1337.80	8983	585.59	1449.59	2722	1402.65	980.32	1493	1317.26				
300% +	41458	997.18	206.98	3829	508.13	1050.80	35408	1112.64	117.85	2224	173.30				
TOTAL	78309	713.07	856.93	25123	453.17	1524.32	39181	1134.62	195.53	14004	1510.23				

TABLE 7-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF \$2000

FAMILY INCOME	REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS					
	FAMILIES (THOUS)	1000+	500- 999	250- 499	100- 249	1- 99	NO CHANGE	1- 99	100- 249	250- 499	500- 999	1000+
11653.		0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5
< 10,000												
5541.		0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	17.5	23.2	42.7
10,000-14,999												
6602.		0.3	2.4	2.1	2.4	4.0	0.0	7.0	11.1	18.6	15.1	37.1
15,000-19,999												
10400.		0.1	4.9	9.5	8.8	8.4	0.5	9.8	7.5	11.6	13.3	25.6
20,000-29,999												
9901.		7.3	19.5	15.7	6.7	6.3	2.7	3.1	5.7	5.6	11.5	15.9
30,000-39,999												
8529.		16.6	28.0	12.7	4.6	6.9	2.7	2.1	3.2	5.5	6.3	11.3
40,000-49,999												
15034.		47.4	22.3	9.4	2.7	5.7	3.7	0.6	1.3	2.1	1.8	3.0
50,000-74,999												
75,000 +		60.6	20.6	4.4	0.2	8.5	4.0	0.3	0.3	0.2	0.7	0.2
INC AS % OF POV												
< POVERTY												
11080.		0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%												
6156.		0.0	1.2	0.8	1.1	1.5	0.2	2.1	4.0	15.5	18.8	54.8
150% - 199%												
6405.		0.9	2.1	1.8	2.2	2.4	0.3	5.8	6.1	15.2	23.8	39.3
200% - 299%												
13198.		2.1	3.7	4.4	4.6	5.9	0.0	7.8	10.7	16.1	19.7	25.1
300% +												
41458.		37.2	23.9	12.0	4.3	7.9	3.7	2.1	2.3	3.0	2.0	1.7
TOTAL												
78309.		20.1	13.6	7.3	3.4	5.5	2.0	3.2	4.2	8.8	11.2	20.6

TABLE 8-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF \$2000

FAMILY INCOME	FAMILIES RECEIVING TAX BENEFITS TODAY										DO NOT NOW GET TAX BENEFIT	
	ALL FAMILIES					WINNERS					LOSERS	
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT
< 10,000	11653.	57.52	1588.07	4263.	125.46	1379.84	152.	889.40	539.87	7238.	1732.84	
10,000-14,999	5541.	182.85	1503.05	3279.	235.23	1452.02	373.	649.25	448.03	1890.	1799.75	
15,000-19,999	6602.	321.59	1412.94	4326.	332.40	1410.68	721.	950.49	627.94	1555.	1783.29	
20,000-29,999	10400.	527.12	1360.66	7061.	541.10	1546.66	2003.	829.76	620.99	1337.	1486.72	
30,000-39,999	9901.	813.46	1368.58	6091.	701.66	1686.40	3212.	1177.17	766.94	598.	1363.45	
40,000-49,999	8529.	874.71	1187.80	4444.	753.78	1687.02	3756.	1094.47	587.29	329.	1301.60	
50,000-74,999	15034.	1173.81	844.28	4315.	906.35	1819.44	10094.	1360.94	445.67	626.	550.18	
75,000 +	10648.	1257.44	286.80	836.	953.63	1974.05	9380.	1342.53	139.95	433.	209.76	
INC AS % OF POV												
< POVERTY	11080.	65.68	1822.93	4181.	144.05	1754.69	132.	953.37	603.02	6768.	1888.86	
100% - 149%	6156.	250.66	1761.75	3650.	331.09	1835.21	288.	1159.99	865.37	2218.	1757.53	
150% - 199%	6405.	491.56	1599.00	4481.	528.54	1670.07	623.	1252.51	793.93	1301.	1739.79	
200% - 299%	13198.	687.80	1499.53	9349.	622.79	1643.57	2356.	1381.93	946.89	1493.	1469.98	
300% +	41458.	997.18	691.41	12955.	686.55	1393.57	26286.	1234.40	356.48	2224.	558.21	
TOTAL	78309.	713.07	1146.00	34615.	545.91	1587.09	29690.	1244.39	418.52	14004.	1598.19	

TABLE 8-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF \$2000

	FAMILIES (THOUS.)	REDUCTION IN TAX BENEFITS					NO CHANGE	INCREASE IN TAX BENEFITS						
		1000+	500- 999	250- 499	100- 249	1- 99		1- 99	100- 249	250- 499	500- 999	1000+		
FAMILY INCOME														
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5		
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	17.0	22.0	44.3		
15,000-19,999	6602.	0.3	2.4	2.1	2.3	3.9	0.0	5.8	8.6	20.2	16.6	37.9		
20,000-29,999	10400.	0.1	1.9	3.0	6.0	8.2	0.0	9.6	8.0	16.4	17.2	29.6		
30,000-39,999	9901.	3.1	5.0	8.3	10.2	6.0	0.1	5.1	9.3	11.5	17.6	23.9		
40,000-49,999	8529.	3.8	13.0	16.2	6.4	4.7	0.7	4.2	7.2	9.1	15.6	19.2		
50,000-74,999	15034.	26.7	19.5	11.6	5.1	4.3	1.7	2.3	4.2	5.5	8.6	10.6		
75,000 +	10648.	52.1	21.0	5.1	1.6	8.3	3.6	0.2	0.7	2.3	1.5	3.6		
INC AS % OF POV														
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3		
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.5	0.2	2.1	4.0	15.3	18.2	55.6		
150% - 199%	6405.	0.9	2.1	1.8	2.0	2.6	0.3	5.8	5.9	14.8	23.3	40.4		
200% - 299%	13198.	2.0	3.3	3.8	4.5	4.3	0.1	6.2	8.9	16.4	19.4	31.1		
300% +	41458.	23.9	15.8	10.4	6.1	7.3	1.7	3.9	5.5	8.3	9.3	7.9		
TOTAL	78309.	13.1	9.2	6.4	4.3	4.9	1.0	3.9	5.6	11.7	15.0	25.1		

TABLE 9-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 200% POVERTY: HIGH RISK ADD-ON OF \$5000

FAMILY INCOME	ALL FAMILIES						FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW	
													GET TAX BENEFIT	
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
< 10,000	11653.	57.52	1709.28	4263.	125.46	1425.00	152.	889.40	539.87	7238.	1901.38			
10,000-14,999	5541.	182.85	1377.60	2633.	211.75	1598.75	1019.	447.27	235.85	1890.	1685.36			
15,000-19,999	6602.	321.59	946.74	1883.	315.45	2045.31	3164.	483.23	92.77	1555.	1354.66			
20,000-29,999	10400.	527.12	572.38	1995.	593.89	2355.10	7069.	607.99	50.89	1337.	689.56			
30,000-39,999	9901.	813.46	208.08	663.	801.28	2495.03	8640.	870.73	14.81	598.	464.27			
40,000-49,999	8529.	874.71	85.56	256.	814.81	2522.81	7944.	912.85	6.84	329.	87.99			
50,000-74,999	15034.	1173.81	46.96	232.	936.44	2342.76	14176.	1229.49	9.59	626.	41.48			
75,000 +	10648.	1257.44	16.62	70.	1461.74	2113.15	10146.	1309.66	2.92	433.	0.00			
INC AS % OF POV														
< POVERTY	11080.	65.68	1948.67	4181.	144.05	1816.37	132.	953.37	603.02	6768.	2056.62			
100% - 149%	6156.	250.66	1755.82	3650.	331.09	1785.75	288.	1159.99	844.52	2218.	1825.20			
150% - 199%	6405.	491.56	1040.38	3024.	389.61	1389.92	2080.	947.32	394.92	1301.	1260.02			
200% - 299%	13198.	687.80	212.53	594.	752.09	3765.94	11110.	776.81	0.00	1493.	379.60			
300% +	41458.	997.18	37.61	546.	906.68	2331.09	38690.	1055.75	4.64	2224.	48.59			
TOTAL	78309.	713.07	554.58	11995.	327.69	1819.57	52310.	992.35	25.31	14004.	1448.17			

TABLE 9-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 200% POVERTY: HIGH RISK ADD-ON OF \$5000

	REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS					
	FAMILIES (THOUS)	1000+	500- 999	250- 499	100- 249	1- 99	NO CHANGE	1- 99	100- 249	250- 499	500- 999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.7	26.9	47.9
10,000-14,999	5541.	0.2	1.3	5.4	4.2	7.4	1.6	4.7	5.4	16.2	14.7	39.0
15,000-19,999	6602.	1.8	8.6	24.4	6.5	6.6	9.6	1.6	1.7	5.7	7.8	25.7
20,000-29,999	10400.	8.6	20.4	27.6	4.1	7.3	9.3	0.7	1.2	3.0	3.8	14.0
30,000-39,999	9901.	29.1	31.8	13.0	3.5	10.0	5.1	0.3	0.6	0.8	1.4	4.6
40,000-49,999	8529.	34.9	36.0	11.9	1.9	8.5	3.7	0.2	0.3	0.0	0.5	2.2
50,000-74,999	15034.	56.6	22.6	7.6	1.2	6.3	4.1	0.1	0.0	0.2	0.2	1.1
75,000 +	10648.	61.9	20.0	4.4	0.2	8.7	4.1	0.0	0.0	0.3	0.2	0.2
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.2	1.1	0.8	1.3	1.3	0.2	2.6	3.7	15.4	20.7	52.8
150% - 199%	6405.	3.6	9.2	7.9	6.6	5.2	0.0	6.1	7.8	19.1	16.6	17.9
200% - 299%	13198.	25.5	23.1	19.4	4.8	11.4	10.3	0.0	0.0	0.0	0.0	5.6
300% +	41458.	44.3	26.1	13.4	1.6	7.9	5.3	0.0	0.1	0.2	0.2	0.9
TOTAL	78309.	28.1	18.6	11.1	2.4	6.7	4.5	0.8	1.4	5.0	6.5	15.0

TABLE 10-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY: HIGH RISK ADD-ON OF \$5000

FAMILY INCOME	FAMILIES RECEIVING TAX BENEFITS TODAY										DO NOT NOW GET TAX BENEFIT	
	ALL FAMILIES					WINNERS					LOSERS	
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT
< 10,000	11653.	57.52	1713.56	4263.	125.46	1431.63	152.	889.40	539.87	7238.	1904.36	
10,000-14,999	5541.	182.85	1544.69	3279.	235.23	1482.64	373.	649.25	442.73	1890.	1869.76	
15,000-19,999	6602.	321.59	1339.58	3717.	317.82	1475.66	1330.	708.00	438.18	1555.	1785.61	
20,000-29,999	10400.	527.12	981.00	3637.	591.93	2100.41	5426.	613.58	191.63	1337.	1139.21	
30,000-39,999	9901.	813.46	644.04	2131.	699.94	2132.15	7172.	915.06	185.36	598.	843.70	
40,000-49,999	8529.	874.71	334.52	1118.	739.08	1993.14	7082.	936.76	63.98	329.	520.39	
50,000-74,999	15034.	1173.81	134.52	596.	1023.04	2963.68	13813.	1233.47	14.80	626.	84.82	
75,000 +	10648.	1257.44	69.10	229.	1323.94	2798.25	9987.	1310.39	9.56	433.	0.00	
INC AS % OF POV												
< POVERTY	11080.	65.68	1948.67	4181.	144.05	1816.37	132.	953.37	603.02	6768.	2056.62	
100% - 149%	6156.	250.66	1823.85	3650.	331.09	1859.55	288.	1159.99	858.52	2218.	1890.74	
150% - 199%	6405.	491.56	1606.90	4458.	522.77	1667.43	646.	1266.96	809.53	1301.	1795.23	
200% - 299%	13198.	687.80	955.38	5857.	483.56	1399.35	6048.	1067.45	486.44	1493.	1173.28	
300% +	41458.	997.18	92.65	1024.	1081.08	3452.66	38211.	1052.94	4.20	2224.	65.19	
TOTAL	78309.	713.07	760.61	18970.	414.90	1753.68	45335.	1058.13	87.18	14004.	1595.56	

TABLE 10-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY: HIGH RISK ADD-ON OF \$5000

	FAMILIES (THOUS)	REDUCTION IN TAX BENEFITS					INCREASE IN TAX BENEFITS									
		1000+	500- 999	250- 499	100- 249	1- 99	NO CHANGE	1- 99	100- 249	250- 499	500- 999	1000+				
FAMILY INCOME																
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5				
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	18.5	23.9	41.0				
15,000-19,999	6602.	0.7	2.1	4.2	7.6	5.3	0.6	8.3	9.8	14.2	12.3	34.8				
20,000-29,999	10400.	2.1	12.2	26.5	6.7	4.8	5.1	2.8	4.1	5.4	9.0	21.4				
30,000-39,999	9901.	16.8	27.8	16.0	4.1	7.7	3.6	1.6	2.6	3.3	5.3	11.0				
40,000-49,999	8529.	28.5	32.9	12.0	2.8	6.9	2.9	0.6	2.2	2.1	2.5	6.7				
50,000-74,999	15034.	55.2	22.3	7.2	1.2	5.9	4.0	0.0	0.3	0.3	0.4	3.1				
75,000 +	10648.	60.5	19.7	4.3	0.6	8.7	4.1	0.0	0.0	0.2	0.4	1.5				
INC AS % OF POV																
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3				
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.5	0.2	2.1	4.2	15.2	18.6	55.0				
150% - 199%	6405.	1.1	1.9	1.9	2.0	2.8	0.3	5.7	6.2	16.2	25.5	36.3				
200% - 299%	13198.	6.9	12.4	12.0	9.3	5.1	0.3	6.7	10.0	12.2	11.1	14.0				
300% +	41458.	43.7	25.7	13.3	1.7	7.9	5.2	0.0	0.0	0.1	0.2	2.3				
TOTAL	78309.	24.4	16.0	9.3	2.8	5.4	2.9	1.9	2.9	6.7	8.9	18.8				

TABLE 11-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF \$5000

	FAMILIES RECEIVING TAX BENEFITS TODAY										DO NOT NOW	
	WINNERS					LOSERS					GET TAX BENEFIT	
	ALL FAMILIES											
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT
FAMILY INCOME												
< 10,000	11653.	57.52	1714.99	4263.	125.46	1433.85	152.	889.40	539.87	7238.	1905.36	
10,000-14,999	5541.	182.85	1567.46	3279.	235.23	1504.94	373.	649.25	445.68	1890.	1897.25	
15,000-19,999	6602.	321.59	1450.18	4312.	331.01	1436.66	735.	946.47	622.57	1555.	1879.14	
20,000-29,999	10400.	527.12	1269.33	5746.	555.69	1716.19	3317.	690.11	412.70	1337.	1474.68	
30,000-39,999	9901.	813.46	1038.32	3823.	701.16	1912.71	5480.	980.71	414.88	598.	1161.11	
40,000-49,999	8529.	874.71	704.41	2331.	746.27	1915.39	5869.	974.78	220.07	329.	764.43	
50,000-74,999	15034.	1173.81	340.55	1432.	908.49	2377.40	12977.	1259.66	120.98	626.	234.49	
75,000 +	10648.	1257.44	105.77	307.	1367.57	3150.65	9909.	1308.94	15.36	433.	17.86	
INC AS % OF POV												
< POVERTY	11080.	65.68	1948.67	4181.	144.05	1816.37	132.	953.37	603.02	6768.	2056.62	
100% - 149%	6156.	250.66	1844.81	3650.	331.09	1882.23	288.	1159.99	862.34	2218.	1911.11	
150% - 199%	6405.	491.56	1653.06	4481.	528.54	1712.11	623.	1252.51	789.69	1301.	1863.14	
200% - 299%	13198.	687.80	1445.66	8983.	585.59	1570.35	2722.	1402.65	980.32	1493.	1544.11	
300% +	41458.	997.18	274.09	4198.	625.80	1669.34	35039.	1104.91	110.55	2224.	216.74	
TOTAL	78309.	713.07	944.73	25493.	473.34	1696.60	38812.	1127.86	189.68	14004.	1668.71	

TABLE 11-8
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF \$5000

	REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS					
	FAMILIES (THOUS)	1000+	500- 999	250- 499	100- 249	1- 99	NO CHANGE	1- 99	100- 249	250- 499	500- 999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	17.5	23.2	42.7
15,000-19,999	6602.	0.3	2.4	2.1	2.4	4.0	0.0	7.0	11.1	18.6	15.1	37.1
20,000-29,999	10400.	0.1	4.9	9.5	8.8	8.4	0.5	9.8	7.5	11.6	13.2	25.7
30,000-39,999	9901.	7.2	19.5	15.7	6.7	6.3	2.7	3.1	5.6	5.5	11.4	16.3
40,000-49,999	8529.	16.6	28.0	12.7	4.6	6.8	2.7	2.1	3.2	5.2	6.1	12.0
50,000-74,999	15034.	47.1	21.8	9.4	2.5	5.5	3.5	0.4	1.2	1.8	1.7	5.1
75,000 +	10648.	59.7	19.7	4.6	0.5	8.5	4.0	0.2	0.2	0.0	0.7	2.0
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.5	0.2	2.1	4.0	15.5	18.6	55.0
150% - 199%	6405.	0.9	2.1	1.8	2.2	2.4	0.3	5.8	6.1	15.2	23.8	39.3
200% - 299%	13198.	2.1	3.7	4.4	4.6	5.9	0.0	7.8	10.7	16.1	19.7	25.1
300% +	41458.	36.8	23.5	12.0	4.3	7.8	3.6	2.0	2.2	2.7	1.8	3.1
TOTAL	78309.	19.9	13.4	7.3	3.4	5.5	2.0	3.1	4.2	8.7	11.1	21.4

TABLE 12-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF \$5000

FAMILY INCOME	FAMILIES RECEIVING TAX BENEFITS TODAY												DO NOT NOW GET TAX BENEFIT	
	ALL FAMILIES						WINNERS							
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
< 10,000	11653.	57.52	1716.12	4263.	125.46	1435.61	152.	889.40	539.87	7238.	1906.14			
10,000-14,999	5541.	182.85	1585.22	3279.	235.23	1522.11	373.	649.25	448.03	1890.	1919.07			
15,000-19,999	6602.	321.59	1491.12	4326.	332.40	1477.29	721.	950.49	627.94	1555.	1929.91			
20,000-29,999	10400.	527.12	1437.04	7061.	541.10	1625.20	2003.	829.76	620.99	1337.	1666.19			
30,000-39,999	9901.	813.46	1453.06	6091.	701.66	1807.78	3212.	1177.17	766.94	598.	1525.97			
40,000-49,999	8529.	874.71	1236.03	4444.	753.78	1779.59	3756.	1094.47	587.29	329.	1301.60			
50,000-74,999	15034.	1173.81	906.92	4354.	914.37	2015.74	10055.	1359.22	440.96	626.	679.36			
75,000 +	10648.	1257.44	343.27	925.	1044.44	2460.39	9291.	1337.21	138.74	433.	209.76			
INC AS % OF POV														
< POVERTY	11080.	65.68	1948.67	4181.	144.05	1816.37	132.	953.37	603.02	6768.	2056.62			
100% - 149%	6156.	250.66	1861.57	3650.	331.09	1900.37	288.	1159.99	865.37	2218.	1927.37			
150% - 199%	6405.	491.56	1685.42	4481.	528.54	1743.35	623.	1252.51	793.93	1301.	1912.84			
200% - 299%	13198.	687.80	1589.82	9349.	622.79	1739.14	2356.	1381.93	946.89	1493.	1669.64			
300% +	41458.	997.18	746.78	13082.	698.10	1555.31	26159.	1231.30	354.84	2224.	598.80			
TOTAL	78309.	713.07	1223.24	34743.	550.77	1696.72	29562.	1241.68	417.34	14004.	1749.97			

TABLE 12-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF \$5000

FAMILY INCOME	FAMILIES (THOUS)	REDUCTION IN TAX BENEFITS					INCREASE IN TAX BENEFITS				
		500- 999	250- 499	100- 249	1- 99	NO CHANGE	1- 99	100- 249	250- 499	500- 999	1000+
< 10,000	11653.	0.1	0.3	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	0.8	3.3	0.6	4.9	4.8	17.0	22.0	44.3
15,000-19,999	6602.	0.3	2.4	2.3	3.9	0.0	5.8	8.6	20.2	16.6	37.9
20,000-29,999	10400.	0.1	1.9	3.0	6.0	0.0	9.6	8.0	16.4	17.2	29.6
30,000-39,999	9901.	3.1	5.0	8.3	10.2	0.1	5.1	9.3	11.5	17.5	24.0
40,000-49,999	8529.	3.8	13.0	16.2	6.4	4.7	4.2	7.2	9.1	15.6	19.2
50,000-74,999	15034.	26.7	19.5	11.5	5.1	4.2	2.3	4.2	5.3	8.4	11.2
75,000 +	10648.	51.7	20.5	4.9	8.4	3.6	0.2	0.7	1.9	1.6	4.8
INC AS % OF POV											
< POVERTY	11080.	0.1	0.3	0.1	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.1	0.2	2.1	4.0	15.3	18.2	55.6
150% - 199%	6405.	0.9	2.1	1.8	2.0	0.3	5.8	5.9	14.8	23.3	40.4
200% - 299%	13198.	2.0	3.3	3.8	4.5	0.1	6.2	8.9	16.4	19.4	31.1
300% +	41458.	23.8	15.6	10.4	6.1	1.7	3.9	5.5	8.1	9.3	8.5
TOTAL	78309.	13.0	9.1	6.3	4.3	1.0	3.9	5.6	11.6	14.9	25.4

***THE CONSUMER CHOICE
HEALTH REFORM PROPOSAL:
ESTIMATED COST AND IMPACTS***

Prepared For:

The Social Security Advisory Council

Prepared By:

*Lewin/ICF
A Health and Sciences International, Inc.*

December 19, 1991

THE CONSUMER CHOICE MODEL

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EMPLOYER RESPONSIBILITY

- **EMPLOYERS MUST CONTRIBUTE TO HEALTH INSURANCE COSTS FOR ALL WORKERS.**
 - *Employers must cover all full-time workers (25 or more hours per week) except seasonal and temporary workers.*
 - *Employers must pay a tax equal to 8 percent of the first \$27,150 in wages for uncovered workers (part-time, seasonal and temporary).^a*
 - *Small employers may pay the 8 percent payroll tax in lieu of offering insurance to full-time workers.*
 - *Self-employed individuals will obtain insurance through a public plan (see discussion below).*
- **WORKING DEPENDENTS ARE REQUIRED TO TAKE COVERAGE ON THEIR OWN JOB.**
- **THE PLAN COVERS:**
 - *Inpatient and Outpatient Hospital Care*
 - *Physicians Services*
 - *Prescription Drugs*
 - *Laboratory and Diagnostic Tests*
 - *Mental Health and Substance Abuse*

^a *The taxable wage base under the plan (\$27,100) is equal to one-half of the Social Security Taxable Wage Base.*

EMPLOYER RESPONSIBILITY

(continued)

- **COST SHARING**

- \$250 Deductible (\$500 Per Family)
- Out-of-Pocket Limit of \$2,000 Per Person (\$4,000 Per Family)

<i>Coinurance</i>	<i>Plan Provisions</i>
<i>Inpatient Hospital Services</i>	
<i>Days 1-30</i>	80%-20%
<i>Days 31-365</i>	50%-50%
<i>Outpatient Hospital Services</i>	80%
<i>Hospital Alternative (Extended or Home Health Care)</i>	Yes
<i>Physician Services</i>	75%
<i>Prenatal/Well Baby/Well Child-Care</i>	100%
<i>Diagnostic Tests</i>	75%
<i>Prescription Drugs</i>	75%
<i>Emergency Services</i>	100%
<i>Mental Health Care</i>	
<i>Inpatient Days 1-21</i>	80%-20%
<i>Inpatient Days 21-365</i>	50%-50%
<i>Outpatient</i>	75%-25%
<i>Dental Care</i>	Not Covered
<i>Routine Physicals and Tests</i>	50%-50%

- **EMPLOYER PAYS 80 PERCENT OF PREMIUM FOR BASIC BENEFITS PACKAGE**

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PERSONS NOT COVERED BY AN EMPLOYER PLAN

- **ALL PERSONS NOT COVERED UNDER AN EMPLOYER PLAN OBTAIN COVERAGE THROUGH THE PUBLIC SPONSOR INCLUDING:**
 - *Part-time and seasonal workers not covered by employer plan*
 - *Non-Workers*
 - *Self-Employed Persons*
- **COVERED SERVICES AND COST SHARING REQUIREMENTS ARE THE SAME AS UNDER THE EMPLOYER PLAN EXCEPT FOR LOW-INCOME FAMILIES.**
- **PREMIUM AND COST SHARING SUBSIDIZED FOR PERSONS BELOW 150 PERCENT OF POVERTY.**
 - *Premium and cost sharing eliminated for persons below poverty.*
 - *Premium and cost sharing phased-in between poverty and 150 percent of poverty.*
 - *All above 150 percent of poverty pay 20 percent of premium and full cost sharing amounts.*
- **SUPPLEMENTAL BENEFITS ARE PROVIDED FOR PERSONS BELOW POVERTY (SEE FIGURE 1).**
- **ALL PERSONS NOT OTHERWISE COVERED BY AN EMPLOYER PLAN PAY AN 8 PERCENT TAX ON AGI UP TO \$27,100.¹**

1 *The taxable wage base varies with family size in proportion to the poverty threshold. The taxable wage base for a family of three was assumed to be \$27,100.*

Figure 1
SUPPLEMENTAL BENEFITS FOR
LOW INCOME INDIVIDUALS

<i>Benefits</i>	<i>Plan Provisions</i>
<i>Private Duty Nursing</i>	<i>100%</i>
<i>Dental Care</i>	<i>100%</i>
<i>Clinic Services</i>	<i>100%</i>
<i>Physical Therapy</i>	<i>100%</i>
<i>Occupational Therapy</i>	<i>100%</i>
<i>Speech, Hearing and Language Disorders</i>	<i>100%</i>
<i>Dentures</i>	<i>100%</i>
<i>Prosthetic Devices</i>	<i>100%</i>
<i>Eyeglasses</i>	<i>100%</i>
<i>Preventive Services</i>	<i>100%</i>
<i>Rehabilitative Services</i>	<i>100%</i>
<i>Inpatient Psychiatric Care for Individuals Under Age 21</i>	<i>100%</i>
<i>Hospice Services</i>	<i>100%</i>
<i>Transportation</i>	<i>100%</i>
<i>Case Management</i>	<i>100%</i>
<i>Early and Periodic Screening, Diagnosis, and Treatment for Individuals Under Age 21</i>	<i>100%</i>
<i>Podiatrists, Optometrist, and Chiropractor Services</i>	<i>100%</i>

STRUCTURAL INCENTIVES TO CONTAIN HEALTH SPENDING

- **PLAN ENCOURAGES AND FACILITATES COST CONSCIOUS DECISION MAKING IN SELECTING COVERAGE.**
- **INCENTIVES FOR INDIVIDUALS TO REDUCE COSTS.**
 - *Employers may provide supplements to the basic benefits package but at full cost to the employee.*
 - *Employees will purchase supplemental insurance coverage out of after-tax income (i.e., the tax exclusion is eliminated for health benefits over minimum standard).*
 - *Employers who currently provide coverage in excess of the basic benefits package are required to shift contributions for these excess benefits to employees as in other forms of compensation.*
- **MANAGED COMPETITION.**
 - *Public sponsors created to aggregate buying power of small employers and individuals.*
 - *Individuals select among plans competing on the basis of price and quality.*
 - *Health plans paid with capitated rates to provide incentives to contain costs.*

KEY ASSUMPTIONS

- **UTILIZATION OF HEALTH SERVICES FOR NEWLY INSURED INDIVIDUALS IS ASSUMED TO INCREASE TO THE LEVEL REPORTED FOR INSURED PERSONS WITH SIMILAR CHARACTERISTICS. (THE UTILIZATION INCREASE FOR NEWLY INSURED PERSONS IS ESTIMATED TO BE \$14.3 BILLION).**
- **EMPLOYER CONTRIBUTIONS FOR INSURANCE IN EXCESS OF THE MINIMUM BENEFIT STANDARDS ARE ASSUMED TO BE CONVERTED TO WAGES AND SALARIES SO THAT TOTAL EMPLOYER COSTS (INCLUDING FICA PAYMENTS) REMAIN UNCHANGED FOR THESE WORKERS. (THE INCREASE IN WAGES AND SALARIES IS ESTIMATED TO BE \$23.6 BILLION).**
- **ALL INDIVIDUALS IN PLANS WHICH EXCEED THE MINIMUM BENEFITS STANDARDS ARE ASSUMED TO SHIFT TO SOME FORM OF MANAGED CARE PLAN IN WHICH HEALTH SPENDING IS REDUCED TO THE POINT WHERE THE EMPLOYEE AFTER TAX PREMIUM CONTRIBUTION IS THE SAME AS UNDER CURRENT POLICY. (THE REDUCTION IN HEALTH SPENDING IS ESTIMATED TO BE \$9.7 BILLION IN 1991).**
- **EMPLOYERS HAVE THE OPTION OF COVERING PART-TIME, SEASONAL AND TEMPORARY WORKERS RATHER THAN PAYING THE PAYROLL TAX. EMPLOYERS ARE ASSUMED TO PROVIDE INSURANCE TO THESE WORKERS WHENEVER THIS IS LESS COSTLY THAN PAYING THE TAX.**

Table 1

**CHANGE IN NATIONAL HEALTH SPENDING
UNDER THE CONSUMER CHOICE MODEL IN 1991
(In Billions)**

Household Payments		\$ 9.8
<i>Tax Payments</i>	<i>47.3</i>	
<i>Premium Payments</i>	<i>(18.8)</i>	
<i>Out-of-Pocket Spending</i>	<i>(18.7)</i>	
Private Employers		7.7
<i>Currently Provide Insurance</i>	<i>(9.6)</i>	
<i>Currently Do Not Insure</i>	<i>17.3</i>	
State and Local Governments		(12.2)
Federal Government (Program Fully Funded)		0.0
Change in National Health Spending		\$5.3
<i>Utilization Increase for Newly Insured</i>	<i>12.2</i>	
<i>Tax Induced Reduction in Utilization</i>	<i>(9.7)</i>	
<i>Net Change in Administrative Costs</i>	<i>2.8</i>	

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 2

SOURCES AND USES OF FEDERAL FUNDS UNDER THE CONSUMER CHOICE MODEL
IN 1991
(In Billions)

Sources of Funds ^a		Uses of Fund	
Employer Payroll Tax For Workers Covered Under Public Plan ^d	\$ 7.3	Benefit Payments	\$102.3
		Workers and Dependents Covered Under Plan ^g	22.6
		Self-Employed and Others ^h	47.2
		Cost-Sharing Subsidies to Low-Income Persons ⁱ	24.8
		Supplemental Benefits ^j	7.7
Premium Payments ^b	10.2	Administrative Costs ^k	5.9
Workers Covered Under Plan	4.3	Workers and Dependents	2.7
Non-Workers	5.9	Non-Workers	3.2
Tax on AGI For Persons Not Covered Under Employer Plan ^c	19.8	Changes in Corporate Tax Revenues ^l	2.4
State Contribution to Public Plan ^d	19.9	Offsets to Other Federal Programs	(27.1)
		Medicaid	(25.4)
		CHAMPUS and Other ^m	(1.7)
Tax on the Value of Benefits Provided in Excess of the Minimum Standard ^e	10.3		
Personal Income Tax Increase ^f	16.0		
Total Sources of Funds	\$ 83.5	Total Uses of Funds	\$ 83.5

(Footnotes on Next Page)

Table 2

**SOURCES AND USES OF FEDERAL FUNDS UNDER THE CONSUMER CHOICE MODEL
IN 1991
(In Billions)**

Footnotes to Previous Table

- a* Employers will pay an eight percent tax on payroll up to \$27,100 for all uninsured workers. These include part-time and seasonal workers and employees in small firms that decide to pay the tax rather than not to purchase insurance.
- b* Individuals not otherwise covered under an employer plan can purchase insurance from the public sponsor by paying 20 percent of the premium (\$25.80 per month). The premium is eliminated for persons below poverty and phased-in between poverty and 150 percent of poverty.
- c* Self-employed persons and everyone else not cover through employment would be required to pay an eight percent tax on adjusted gross income (AGI) up to a ceiling which varies with family size. The ceiling is assumed to be \$27,100 for a family of three and varies with family size in proportion to the poverty threshold.
- d* States are assumed to transfer to the program all funds currently used to finance the state share of Medicaid spending for acute care. Medicaid is assumed to be retained for long-term care.
- e* Employers that now contribute to insurance in excess of the minimum standard are assumed to shift these contributions to employees in the form of wages and salaries which become subject to FICA and personal income taxes.
- f* The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (3.26 percent).
- g* Workers covered under the public fund include workers in small firms and part-time and seasonal workers where the employer decided to pay the tax rather than purchase insurance.
- h* Includes self-employed persons and others not otherwise covered by employer plans.

Table 2

**SOURCES AND USES OF FEDERAL FUNDS UNDER THE CONSUMER CHOICE MODEL
IN 1991
(In Billions)**

**Footnotes to Previous Table
(continued)**

- i* The program pays cost sharing for all persons below poverty and phases in cost sharing through 150 percent of poverty.
- j* Includes the cost of supplemental benefits for persons below poverty.
- k* Administrative costs are assumed to equal 12 percent of claims for the workers component of the program; 5.0 percent of claims for self-employed and others covered under the public plan; and 2.7 percent of the cost of subsidies to low income persons.
- l* Employers are assumed to absorb the cost of expansions in coverage resulting in changes in corporate income tax deductions for health benefits and tax payments.
- m* Includes the change in insurance cost for federal employees and CHAMPUS beneficiaries.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 3
CHANGE IN PRIVATE EMPLOYER SPENDING UNDER THE CONSUMER CHOICE MODEL
IN 1991
(In Billions)

	<i>Firms That Now Offer Insurance</i>	<i>Firms That Do Not Insure</i>	<i>All Firms</i>
<i>Current Employer Expenditures for Health Care</i>	\$115.5	—	\$115.5
<i>Increases in Employer Cost</i>			
<i>Cover Persons Not Now Insured at Minimum Standard Benefits^d</i>	14.3	30.6	44.9
<i>Minimum Benefit Standard^d</i>	2.0	--	2.0
<i>Cost Offsets Under Plan</i>			
<i>Limit on Employer Costs to 8 Percent of Payroll for:^e</i>			
Part-Time and Seasonal Workers	(2.1)	(1.2)	(3.3)
Small Employers	(0.8)	(6.4)	(7.2)
<i>Working Dependents Shifted to Their Own Job^d</i>	(21.0)	--	(21.0)
<i>Cost Shift Savings</i>	(5.2)	--	(5.2)
<i>Total Employer Cost</i>	102.7	23.0	125.7
<i>Net Change in Employer Costs</i>	(12.8)	23.0	10.2
<i>Change in Tax Payments</i>	3.2	(5.7)	(2.5)
<i>Net After Tax Change in Employer Costs</i>	\$ (9.6)	\$17.3	\$ 7.7

(Footnotes on next page)

Table 3

**CHANGE IN PRIVATE EMPLOYER SPENDING UNDER THE CONSUMER CHOICE MODEL
IN 1991
(In Billions)**

- a** Insurance costs for persons not now covered under existing plans (part-time, seasonal, etc.)
- b** Employer plans that do not provide the minimum level of benefits will be required to upgrade to conform to the minimum standard.
- c** Employer expenditures for health benefits are effectively capped at 8 percent of payroll for small employers and employers of part-time and seasonal workers.
- d** Working dependent spouses will be required to take coverage on their own job. Dependent children in two worker families will also be allocated across the two employers.

***** **Note:** We assume that employers that now provide coverage in excess of the minimum standard shift the premium contribution over the allowed amount to the employee in the form of increased wages and salaries. Thus, the limitation on employer health benefits contributions under the Consumer Choice Model is assumed to have no effect on total employer compensation costs.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 4

**IMPACT OF THE CONSUMER CHOICE MODEL ON
STATE AND LOCAL GOVERNMENTS IN 1991**

(In Billions)

	<i>Change in Expenditures</i>
<i>Changes in Employee Benefit Costs</i>	<i>\$(1.7)</i>
Current Employee Benefit Costs 23.9	
Change in Employee Benefits Costs (1.7)	
Total Employee Benefit Costs 22.2	
<i>Change in Medicaid Spending^a</i>	<i>0.0</i>
<i>Savings to Public Hospitals and Other Programs^b</i>	<i>(9.4)</i>
<i>Change in State Income Taxes Due to Changes in Wages and Salaries</i>	<i>(1.2)</i>
<i>Reduction in Corporate Tax Payments</i>	<i>0.1</i>
<i>Net Impact on State and Local Governments</i>	<i>\$(12.2)</i>

a All funds currently allocated to the Medicaid program are assumed to be transferred to the public program.

b Public hospitals that now serve indigent patients will be reimbursed for services provided to patients who become insured under the program.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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Table 5

**CHANGE IN HOUSEHOLD HEALTH SPENDING
UNDER THE CONSUMER CHOICE MODEL IN 1991
(In Billions)**

	Change From Current Policy
Individual Premium Payments	
<i>Net Change in Employee Share of Employer Plan Premium^a</i>	<i>(18.6)</i>
<i>Non-Group Premium Payment</i>	<i>(10.4)</i>
<i>Premium Payments For Persons Covered Under Public Plan</i>	<i>10.2</i>
Tax Payments	
<i>Change in Federal Taxes Due to Changes in Wages and Salaries</i>	<i>\$10.3</i>
<i>Change in State Taxes Due to Changes in Wages and Salaries</i>	<i>1.2</i>
<i>Personal Income Tax Increase</i>	<i>16.0</i>
<i>Tax on AGI For Persons Not Covered by An Employer Plan</i>	<i>19.8</i>
Direct Payments for Care	
<i>Households Out-of-Pocket Expenditures</i>	<i>(18.7)</i>
<i>Net Change in Household Health Spending</i>	<i>\$ 9.8</i>

a Includes changes in employee premium payments net of increases in wages and salaries for persons covered under plans which exceed minimum benefits standards.

b Includes FICA and increased personal income tax payments on increased wages and salaries for currently insured workers in firms that exceed the minimum benefits standard.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Lewin/ICF

***THE PUBLIC/PRIVATE PARTNERSHIP PLAN:
FOR UNIVERSAL ACCESS
ESTIMATED COST AND IMPACTS***

Prepared For:

The Social Security Advisory Council

Prepared By:

***Lewin/ICF
A Health and Sciences International, Inc.***

December 19, 1991

THE PUBLIC/PRIVATE PARTNERSHIP PLAN

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THE PUBLIC/PRIVATE PARTNERSHIP PLAN

- **MEDICARE CHANGES**
 - All persons age 60 and over covered under Medicare
 - \$2,000 out-of-pocket expenditure cap per family
 - Individual Part B premium is reduced by half
 - Cover all state and local workers under Medicare
- **FIRMS WITH UNDER 25 WORKERS COVERED UNDER MEDICARE**
 - Employer pays community-rated fee to Medicare:
 - 80 percent paid by employer;
 - 20 percent paid by employee
 - Refundable tax credit for 40 percent of employer cost in firms with average payroll below twice the minimum wage.
- **FIRMS WITH 25 OR MORE WORKERS MUST PROVIDE INSURANCE**
 - Community rated premium varied by age and geographic location
 - Employer pays 80 percent of premium
 - 80 percent of expenditures over \$25,000 covered under Medicare
 - \$2,000 out-of-pocket expenditure cap
 - Employers may purchase coverage through Medicare
- **INTER-EMPLOYER EQUITY PROVISIONS**
 - Working spouses take coverage on own job
 - Dependents allocated across employers in two worker family
- **NON-WORKERS COVERED UNDER MEDICARE**
- **SUPPLEMENTAL MEDICAID BENEFITS TO PERSONS BELOW POVERTY**

REVENUE PROVISIONS

- **TAXABLE WAGE LIMIT ELIMINATED FOR EMPLOYER PORTION OF HI PAYROLL TAX (CURRENTLY \$125,000) FOR ALL WORKERS**
- **EMPLOYER MEDICARE PAYROLL TAX INCREASE OF 0.75 PERCENT TO COVER MEDICARE SUBSIDIES TO EMPLOYER COVERAGE**
- **ESTATE TAX DOUBLED**
- **TAX 85 PERCENT OF SOCIAL SECURITY BENEFITS**
- **THREE PERCENT TAX ON UNEARNED INCOME (EXCLUDING SOCIAL SECURITY) UP TO \$125,000 WHERE TAXABLE UNEARNED INCOME IS OFFSET BY EARNINGS SUBJECT TO HI PAYROLL TAX**
- **FEDERAL INCOME TAX INCREASE OF \$49.2 BILLION**

TABLE 1

**CHANGE IN NATIONAL HEALTH SPENDING UNDER
THE PUBLIC/PRIVATE PARTNERSHIP PLAN IN 1991
(in billions)**

Household Expenditures		\$30.2
Premiums and Out-of-Pocket Payments	(\$48.2)	
Tax Payments	\$78.4	
State Governments		(5.9)
Local Governments (Public Hospitals)		(8.5)
Net New Federal Spending (Program Fully Funded)		0.0
Employers		21.8
Currently Insuring Firms	(0.8)	
Firms That Do Not Insure	22.6	
Provider Uncompensated/Undercompensated Care^a		(10.8)
Net Change in National Health Spending		\$26.8

a Includes reduction in hospital uncompensated care and increased reimbursement for persons previously covered under Medicaid.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

TABLE 2
MEDICARE REVENUES AND EXPENDITURES UNDER THE PUBLIC/PRIVATE
PARTNERSHIP PLAN ASSUMING FULL IMPLEMENTATION IN 1991
(in billions)

PROGRAM REVENUES		PROGRAM EXPENDITURES	
Funding for Current Beneficiaries ^a		Current Medicare Beneficiaries ^a	
HI Payroll Tax	\$ 88.6	HI Benefits and Administration	\$ 71.7
SMI General Revenue Contribution	41.2	SMI Benefits and Administration	52.2
Individual Part B Premium (Premium Eliminated)	6.2	\$2,000 Cap on Out-of-Pocket Spending	18.6
Subtotal Current Beneficiaries	\$136.0	Subtotal Current Beneficiaries	\$142.5
Revenues for Employer Programs		Medicare Employer Programs	
Employer Premium for Small Firms ^b	\$ 38.9	Cover Workers and Dependents in Small Firms (Under 25 Employees) ^b	\$ 48.7
Employee Premium in Small Firms ^b	9.8	Medicare Stop-Loss for High Cost Cases (Over \$25,000) ^c	5.3
Employer Payroll Tax to Cover Employer Savings (0.75 Percent) ^c	24.8	Subtotal Employer Programs	\$ 54.0
Subtotal Employer Programs	\$ 73.5	Medicare Eligibility Coverage Expansions ^d	
Supplemental Financing		Cover All Persons Age 60 and Older	\$ 20.8
OASDI Tax Transfer (2.2 Percent of Payroll) ^d	\$ 59.3	Cover Nonworkers Under Age 60	56.3
Tax 85 Percent of OASDI Benefits	3.9	Home Health Benefits	15.9
Estate Tax Increase ^e	11.5	Subtotal Eligibility Expansion	\$ 93.0
State Contribution for Home Health ^f	7.9		
Subtotal Employer Programs	82.6	Program Surplus	\$ 2.6
Total Medicare Revenues	\$292.1	Total Medicare Expenditures	\$292.1

TABLE 2
MEDICARE REVENUES AND EXPENDITURES UNDER THE PUBLIC/PRIVATE
PARTNERSHIP PLAN ASSUMING FULL IMPLEMENTATION IN 1991
(Continued)

- a The HI payroll tax and SMI general revenue contributions will continue as under current law. The individual Part B premium payments are reduced by half. The taxable wage limit for the HI tax is eliminated (it is currently \$125,000) and coverage is extended to all state and local workers.
- b Small firms will pay a community rated premium (varied by age and geographic region) equivalent to the cost of covering workers and dependents under Medicare. Employers will pay 80 percent of the premium, with employees paying 20 percent.
- c The employer share of the Medicare payroll tax would be increased by 0.75 percent to cover savings to employers attributable to: (1) covering workers and dependents age 60 and over under Medicare; (2) Medicare stop-loss insurance for high cost cases (over \$25,000); and (3) savings in worker and retiree benefits due to the \$2,000 cap on out-of-pocket expenses for Medicare enrollees. The tax applies to the full amount of payroll for all workers.
- d OASDI will be put on a pay-as-you-go basis with excess payroll tax revenues (2.2 percent of payroll) transferred to Medicare.
- e Estate taxes will be doubled with the full amount earmarked for Medicare.
- f States are required to pay half of the cost of the Medicare home health expansion.
- g Medicare HI and SMI benefits will be combined into a single program with a \$2,000 cap on out-of-pocket spending. The HI trust fund balance is assumed to increase as projected under current law in 1991.
- h Workers and dependents in firms with under 25 employees will be covered under Medicare.
- i A Medicare stop-loss program is established to cover high cost cases in privately insured firms with 25 or more employees. The program will cover 80 percent of costs for individual cases in excess of \$25,000.
- j Medicare coverage is extended to cover persons age 60 and over and all nonworkers under age 60. These estimates include the cost of extending coverage to persons receiving social security disability payments who are not currently eligible for Medicare. These estimates also include the cost of covering persons age 65 and older who are not now eligible for Medicare and the cost of restoring Medicare as primary payor for workers and dependents with employer coverage who are also covered under Medicare.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

TABLE 3
IMPACT OF THE PUBLIC/PRIVATE PARTNERSHIP PLAN ON THE FEDERAL
GOVERNMENT ASSUMING FULL IMPLEMENTATION IN 1991
(in billions)

SOURCES OF FUNDS		USES OF FUNDS	
Tax on Unearned Income	\$13.2	Medicare General Revenue Requirement (See Table 2)	(\$2.6)
Personal Income Tax Payment	49.2	Reduced HI Trust Fund Balance ^a	12.6
		Reduced OASDI Trust Fund Balance ^b	59.3
		Change in Medicaid Program Costs (See Table 5)	(16.3)
		Savings in Other Federal Health Programs ^c	(3.4)
		Tax Credit for Employers of Low Wage Workers	6.3
		Corporate Income Tax Loss ^d	6.5
Total Revenues	\$62.4	Net Federal Revenue Requirement	\$62.4

- a The HI Trust Fund balance is projected to grow by \$12.6 billion under current policy in 1991. These funds would be used to pay for Medicare program expansions which represents an increase in the federal deficit.
- b OASDI payroll tax revenues will be transferred to the Medicare program as Social Security is placed on a pay-as-you-go basis which represents an increase in the federal deficit.
- c There will be savings under CHAMPUS and the federal civil service employees programs as working spouses become covered on their own job and children are allocated across employer plans in two worker families. There will also be savings in federal direct services programs.
- d Employers can deduct insurance expenditures as a cost of doing business.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

TABLE 4
CHANGE IN MEDICAID PROGRAM COSTS FOR ACUTE CARE ONLY UNDER THE
PUBLIC/PRIVATE PARTNERSHIP PLAN IN 1991
(in billions)

	Total Program	Federal Cost	State Cost
A. Current Medicaid Program (Acute Care Only)	\$45.3	\$25.3	\$20.0
OFFSETS TO EXISTING PROGRAM			
B. Coverage for All Workers	(2.0)	(1.1)	(0.9)
C. Nonworkers Covered Under Medicare	(30.5)	(17.1)	(13.4)
D. \$2,000 Out-of-Pocket Limit for Medicare Recipients	(4.8)	(2.7)	(2.1)
E. Total Offsets (B+C+D)	(\$37.3)	(\$20.9)	(\$16.4)
SUPPLEMENTAL PROGRAM COSTS			
F. Supplemental Benefits for Current Medicaid Recipients (A+E)	8.0	4.4	3.6
G. Supplemental Benefits for All Others Below Poverty	7.2	4.6	2.6
H. Total Supplemental Program	\$15.2	\$9.0	\$6.2
NET CHANGE IN MEDICAID COSTS			
I. Net Change (A-H)	(\$28.8)	(\$16.3)	(\$13.8)

a Includes benefits and administration for acute care only. Excludes long-term care.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

TABLE 5
CHANGE IN NUMBER OF PERSONS BY PRIMARY SOURCE OF COVERAGE IN AN
AVERAGE MONTH UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN IN 1991
(in millions)

	CHANGE IN COVERAGE					Primary Source of Coverage Under Policy
	Primary Source of Coverage Under Current Policy	Persons Age 60-64 Covered Under Medicare	Cover Small Firms Under Medicare	Cover Non-Workers Under Medicare	Employer Coverage of Workers in Large Firms	
Employer Coverage	140.6	(2.4)	(34.6)	0.0	14.4	126.7
Non-Group Coverage	19.9	(2.1)	(7.9)	(2.0)	(8.8)	0.0
CHAMPUS/Military	9.3	0.0	(2.4)	0.0	(2.2)	4.7
Medicare	28.1	4.8	57.8	27.1	0.0	117.8
Medicaid	15.9	(0.2)	(1.0)	(14.2)	(0.5)	0.0
Uninsured	35.4	(1.0)	(11.9)	(10.9)	(11.6)	0.0
All Persons	249.2	--	--	--	--	249.2

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

TABLE 6

**CHANGE IN SPENDING UNDER THE PUBLIC/PRIVATE
PARTNERSHIP PLAN FOR EMPLOYERS WHO NOW
OFFER INSURANCE IN 1991**
(in billions)

Current Employer Expenditures for Health Care ^a	\$143.8
ADDITIONAL COSTS UNDER POLICY	
Coverage of Currently Excluded Members ^b	1.6
Minimum Employer Premium and Cost Sharing Provisions ^c	3.1
Increased Payroll Tax Payments ^d	21.7
Total Increases in Cost	\$ 26.4
COST OFFSETS UNDER POLICY	
Medicare Stop-Loss Coverage ^e	(2.9)
Workers Age 60-64 Covered Under Medicare ^f	(9.5)
Savings in Retiree Health Benefits	(5.8)
Working Spouses Covered on Own Job ^g	(7.9)
Tax Credit for Employers of Low Wage Workers ^h	(1.4)
Total Offsets	(\$27.5)
NET CHANGE IN EMPLOYER COSTS	
Net Change Under Policy	(1.1)
Change in Corporate Income Tax Payments ⁱ	0.3
Net After Tax Change in Employer Costs	(0.8)

(Footnotes on Next Page)

TABLE 6

**CHANGE IN SPENDING UNDER THE PUBLIC/PRIVATE
PARTNERSHIP PLAN FOR EMPLOYERS WHO NOW
OFFER INSURANCE IN 1991
(Continued)**

- a Includes employer contributions for health benefits for workers, dependents and retirees.
- b Many employer health plans currently exclude part-time and seasonal workers from coverage. Employers would be required to cover these workers.
- c Employers are required to pay 80 percent of the cost for the minimum standard level of coverage. About 20 percent of firms that now offer coverage will be required to upgrade coverage to conform to these standards.
- d An employer payroll tax equal to 0.75 percent of payroll is created to pay for savings to employer plans due to Medicare expansions. The taxable payroll limit for the HI payroll tax is also eliminated.
- e Medicare will pay 80 percent of claims for individuals in employer plans with expenditures in excess of \$25,000.
- f Includes savings due to: (1) coverage of workers age 60 and over under Medicare; and (2) savings to employer plans due to the \$2,000 out-of-pocket limit for workers covered under the existing Medicare program.
- g Working dependent spouses will be required to take coverage on their own job and dependent children will be allocated across employer plans in two worker households.
- h The employer tax credit would reimburse employers for 40 percent of the employer share of the cost of insurance for firms with 25 or fewer employees where average earnings per worker are less than twice the minimum wage.
- i Employer expenditures for health care are deductible in determining corporate income tax payments.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

TABLE 7

**CHANGE IN SPENDING UNDER THE PUBLIC/PRIVATE
PARTNERSHIP PLAN FOR EMPLOYERS WHO DO NOT
NOW OFFER INSURANCE IN 1991
(in billions)**

Coverage of Uninsured Workers	\$31.3
Payroll Tax to Fund Employer Subsidies	6.9
OFFSETS TO PROGRAM COST	
Workers Age 60-64 Covered Under Medicare	(2.5)
Catastrophic Limit on Employer Cost	(1.4)
Net Impact on Employer Costs	29.4
TAX EFFECTS	
Corporate Income Tax Offset	(6.8)
Tax Credit for Employers of Low-Wage Workers	(4.9)
After-Tax Employer Cost	\$22.6

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

TABLE 8

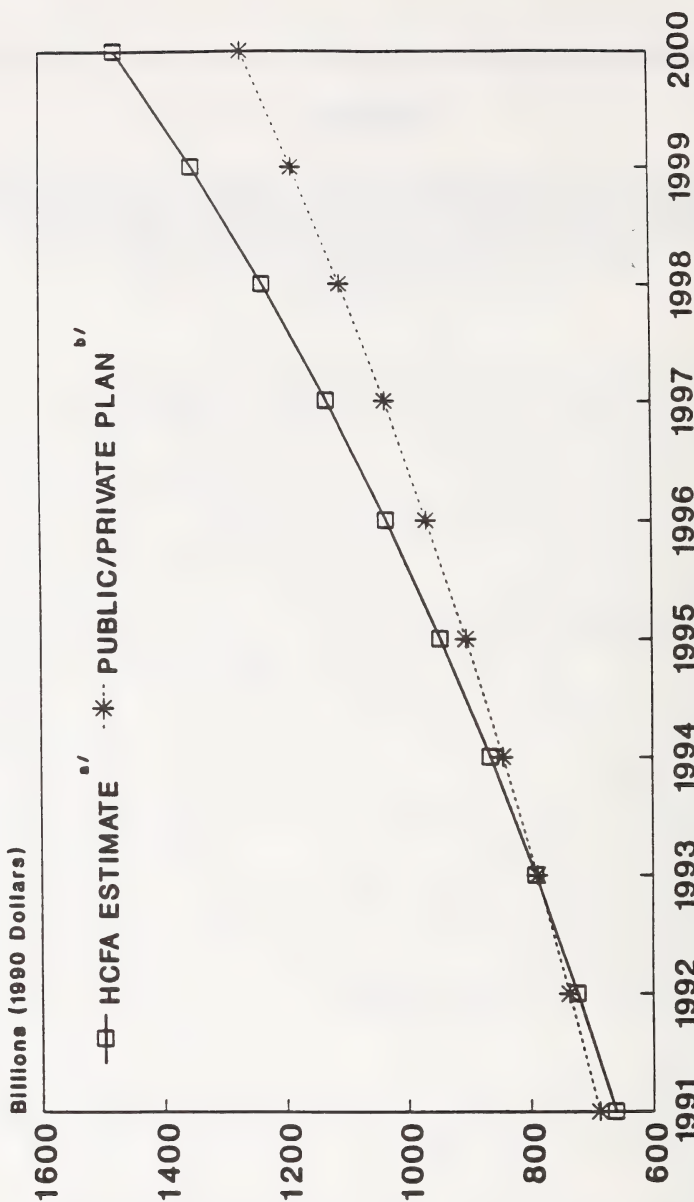
**CHANGE IN HOUSEHOLD SPENDING UNDER THE
PUBLIC/PRIVATE PARTNERSHIP PLAN IN 1991
(in billions)**

PREMIUM AND OUT-OF-POCKET PAYMENTS	
Employer Plan Premium Payments	(\$1.2)
Non-Group Premium Payments	(19.5)
Out-of-Pocket Payments for Care	(21.3)
Part B Premium Payments	(6.2)
Total Premium and Out-of-Pocket	(\$48.2)
HOUSEHOLD TAX PAYMENTS	
Tax 85 Percent of Social Security	\$3.9
Estate Tax Increase	11.5
Tax on Unearned Income	13.2
Personal Income Tax Payments ^a	49.2
HI Tax for State and Local Workers Not Now Covered	0.6
Total Tax Payments	\$78.4
Net Change in Household Spending	\$30.2

^a The marginal rates of the federal personal income tax would be increased by 10 percent. For example, the 28 percent rate would increase to 31.0 percent and the 31.5 percent rate would increase to 34.9 percent.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

NATIONAL HEALTH SPENDING UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN 1991 - 2000



a/ HCFA estimates per capita health spending will grow 8.6% annually between 1991 and 2000.

b/ Assumes the annual growth in per capita health spending is slowed to 6.5% under the expenditure target system implemented by the public/private partnership plan.

Source: Lewin/ICF estimates.

***THE EMPLOYER MANDATE PROPOSAL:
ESTIMATED COST AND IMPACTS***

Prepared For:

The Social Security Advisory Council

Prepared By:

***Lewin/ICF
A Health and Sciences International, Inc.***

December 19, 1991

THE EMPLOYER MANDATE PROPOSAL

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OVERVIEW OF PLAN

- **REQUIRE EMPLOYMENT-BASED INSURANCE FOR ALL FULL-TIME WORKERS AND THEIR FAMILIES.**
- **MEDICAID EXPANSION FOR ALL PERSONS LIVING BELOW POVERTY REGARDLESS OF CATEGORICAL ELIGIBILITY.**
- **MEDICARE IS REFORMED TO PROVIDE CATASTROPHIC COVERAGE, WITH DEDUCTIBLES WHICH VARY WITH INCOME.**
- **CREATION OF STATE RISK POOLS TO OFFER SUBSIDIZED ACCESS TO INSURANCE FOR THOSE NOT INSURED THROUGH ANOTHER SOURCE.**
- **MEDICAL IRAs TO ENCOURAGE INDIVIDUALS TO SAVE FOR ENHANCED BENEFITS, INCLUDING LONG-TERM CARE INSURANCE.**

EMPLOYER RESPONSIBILITY

- **EMPLOYERS MUST INSURE ALL EMPLOYEES WORKING 17.5 HOURS OR MORE PER WEEK AND THEIR DEPENDENTS:**
 - *The mandate would be phased-in over three years by size of employer (e.g., 25+, 10-25, all)*
 - *Employers would be required to offer at least the minimum benefits package¹ (shown on next page)*
 - *The employer is required to pay 80 percent of the premium for workers and dependents*
 - *Individuals are permitted to decline coverage only if they are covered through another source.*
- **TAX MODIFICATIONS FOR EMPLOYERS OFFERING INSURANCE.**
 - *Self-employed individuals would be permitted to deduct 100 percent of health insurance costs.*
 - *New businesses would be permitted to deduct 150 percent of their health insurance costs in their first year, and 125 percent of their costs in their second year. In the third year and beyond, these businesses would be permitted to deduct 100 percent of their costs.*
 - *Businesses of 25 or fewer employees would be eligible for a 100 percent refundable tax credit for health benefit costs in excess of a specified percentage of payroll costs (e.g., 15 percent).*

¹ *Employers would also be required to offer an optional package providing unlimited physician and hospital coverage at an added cost to the employee.*

BENEFITS PACKAGE

- **COST SHARING:**

- \$350 Deductible (\$750 Per Family)
- Out-of-Pocket limit of \$1,500 per person (\$3,000 per family)

<i>Benefit</i>	<i>Coinsurance</i>
<i>Inpatient Hospital Services (45 days per person year)</i>	<i>80%</i>
<i>Outpatient Hospital Services</i>	<i>80%</i>
<i>Physician Services (up to 20 office visits per person per year)</i>	<i>80%</i>
<i>Dialysis Care</i>	<i>80%</i>
<i>Prenatal and Postnatal Care</i>	<i>100%</i>
<i>Pregnancy Care Including Complications and Delivery</i>	<i>100%</i>
<i>Diagnostic and Therapeutic Services</i>	<i>80%</i>
<i>Diagnostic Imaging</i>	<i>80%</i>
<i>Prescription Drugs (Inpatient Only)</i>	<i>80%</i>
<i>Emergency Services</i>	<i>80%</i>
<i>Dental Care (Repair of Insured Teeth or Jaw)</i>	<i>80%</i>
<i>Immunizations and Well Child Care (up to Age 8)</i>	<i>100%</i>
<i>Laboratory Services</i>	<i>80%</i>
<i>Home Health Services (240 Visits Per Person Per Year)</i>	<i>80%</i>
<i>SNF (180 Days Per Persons Per Year)</i>	<i>80%</i>

- **MEDICAID COVERS COST SHARING FOR WORKERS BELOW POVERTY.**

MEDICAID EXPANSION

- **MEDICAID WOULD BE EXPANDED TO COVER ALL BELOW POVERTY:**
 - *Eliminate categorical eligibility limitations*
 - *Poverty levels vary with cost of living in state.*
- **ESTABLISH A NATIONAL MINIMUM MEDICAID BENEFIT STANDARD.**

<i>Benefits</i>	<i>Plan Provisions</i>
<i>Inpatient Hospital Services</i>	<i>100%</i>
<i>Outpatient Hospital Services</i>	<i>100%</i>
<i>Physician Services</i>	<i>100%</i>
<i>Emergency Services</i>	<i>100%</i>
<i>Rural Health Clinic Services</i>	<i>100%</i>
<i>Diagnostic Tests</i>	<i>100%</i>
<i>Prescription Drugs</i>	<i>100%</i>
<i>Home Health Services</i>	<i>100%</i>
<i>Early and Periodic Screening, Diagnosis, and Treatment for Individuals Under Age 21</i>	<i>100%</i>
<i>Family Planning</i>	<i>100%</i>
<i>Rehabilitative Services</i>	<i>100%</i>

- **PROVIDER REIMBURSEMENT UNDER MEDICAID WOULD INCREASE TO LEVELS COMPARABLE TO MEDICARE.**
- **THE CURRENT FEDERAL/STATE MATCH IS ASSUMED TO BE RETAINED.**

STATE RISK POOLS

- **ALL STATES WOULD ESTABLISH RISK POOLS TO MAKE INSURANCE AVAILABLE TO ALL THOSE WHO REMAIN UNINSURED:**
 - *Risk pools would be required to offer health plans including the same set of minimum benefits as the employer plans.*
 - *Risk pool rates would be set at standard group rates.*
- **PERSONS WITH INCOMES BETWEEN 100 AND 150 PERCENT OF POVERTY WOULD RECEIVE PREMIUM SUBSIDIES ON A SLIDING SCALE.**
- **INSURANCE COMPANY CONTRIBUTIONS AND/OR STATE TAX REVENUES WOULD FUND THE POOLS. ERISA WOULD BE AMENDED TO REQUIRE THAT SELF-INSURED PLANS AND HMOs MAY BE ASSESSED TO FINANCE RISK POOL EXPENDITURES IN EXCESS OF PREMIUMS.**

MEDICARE RESTRUCTURING

- **MEDICARE WOULD BE REFORMED TO BECOME A PREFUNDED PROGRAM PROVIDING VOUCHERS TO BENEFICIARIES FOR THE PURCHASE OF ENHANCED INSURANCE COVERAGE IN THE PRIVATE MARKET. THE ELIGIBILITY AGE WOULD BE INCREASED TO 67.**
- **CURRENT MEDICARE BENEFITS WOULD BE ENHANCED TO INCLUDE CATASTROPHIC COVERAGE.**
- **INCOME RELATED DEDUCTIBLES WOULD BE INSTITUTED.**
- **THE EMPLOYER HI PAYROLL TAX WOULD BE INCREASED INCREMENTALLY OVER 20 YEARS AND EMPLOYEE HI TAX WOULD BE REPLACED BY A TAX ON ADJUSTED GROSS INCOME TO FINANCE BOTH CURRENT BENEFITS AND PREFUNDING OF FUTURE BENEFITS.**

MEDICAL IRA'S

- **TAX DEDUCTIBLE CONTRIBUTIONS TO MEDICAL IRAs WOULD BE PERMITTED.**
 - *Annual contributions limited to \$500 for a single individual and \$1,000 for a husband and wife.*
 - *Both the contribution and interest earned will be exempt from taxation as long as it is withdrawn only for health purposes.*
- **MEDICAL IRA's MAY BE CASHED OUT ONLY TO COVER MEDICAL EXPENSES.**

COST CONTAINMENT

- ***IMPLEMENT PROFESSIONAL LIABILITY REFORM TO REDUCE MALPRACTICE INSURANCE COSTS AND REDUCE THE PRACTICE OF DEFENSIVE MEDICINE.***
- ***DEVELOP PRACTICE PARAMETERS (I.E., GUIDELINES, STANDARDS, AND OTHER PATIENT CARE STRATEGIES) TO HELP ASSURE THAT ONLY APPROPRIATE SERVICES ARE DELIVERED.***
- ***LIMIT THE AMOUNT OF EMPLOYER PROVIDED HEALTH INSURANCE THAT IS TAX EXEMPT TO THE EMPLOYEE, AND PERMIT TAX-FREE REBATES TO EMPLOYEES WHO SELECT LESS COSTLY INSURANCE OFFERED BY THEIR EMPLOYER.***
- ***REPEAL OR OVERRIDE STATE-MANDATED BENEFIT LAWS.***
- ***ENCOURAGE HEALTH PROMOTION AND DISEASE PREVENTION (E.G., ANTI-SMOKING EFFORTS, DRUG ABUSE EFFORTS, ETC.)***
- ***SEEK REDUCTIONS IN ADMINISTRATIVE COSTS THROUGH UNIFORM CLAIM FORMS AND REDUCTIONS IN REVIEW REQUIREMENTS.***

ASSUMPTIONS

- **ENROLLMENT ASSUMPTIONS:**
 - *All workers are assumed to take employer coverage for themselves and their dependents when offered.*
 - *All persons eligible for Medicaid are assumed to enroll.*
 - *All persons not otherwise covered are assumed to enroll in the state risk pool.*
- **UTILIZATION OF HEALTH SERVICES FOR PREVIOUSLY UNINSURED PERSONS IS ASSUMED TO ADJUST TO THE LEVEL REPORTED BY INSURED PERSONS WITH SIMILAR CHARACTERISTICS.**
- **THE RESTRUCTURING OF COVERAGE AND DEDUCTIBLES UNDER MEDICARE IS ASSUMED TO BE DONE IN SUCH A WAY THAT IT WILL HAVE NO NET IMPACT ON MEDICARE PROGRAM COSTS.**
- **THE MEDICAID EXPANSION AND MEDICAL IRA PROGRAMS ARE ASSUMED TO BE FINANCED BY AN ACROSS-THE-BOARD PROPORTIONAL INCREASE IN PERSONAL INCOME TAXES:**
 - *Income Tax Increase: \$ 21.2 billion.*
 - *Personal income tax rates increased by 4.3 percent (e.g., the 28 percent rate increases to 29.21 percent).*

Table 1

**CHANGE IN NATIONAL HEALTH SPENDING
UNDER THE EMPLOYER MANDATE PROPOSAL IN 1991
(In Billions)**

Household Payments	7.9
Tax Payments	27.9
Premium Payments	(8.6)
Out-of-Pocket Spending	(11.4)
Private Employers	14.2
Currently Provide Insurance	4.9
Currently Do Not Insure	9.3
State Governments (Program Fully Funded)^a	0.0
Federal Government (Program Fully Funded)^a	0.0
Local Governments	(3.9)
Change in National Health Spending	\$18.2
Utilization Increase for Newly Insured	12.2
Net Increase in Provider Reimbursement ^b	4.2
Net Change in Administrative Costs	1.8

^a We assume that state and federal governments raise the revenues needed to fully fund the program so that the proposal has no net impact on government spending.

^b Increases in Medicaid reimbursement for hospital services are assumed to be passed-on to employers in the form of cost-shift savings. Increases in physician reimbursement are assumed to be retained as income.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 2

IMPACT OF THE EMPLOYER MANDATE PROPOSAL ON PRIVATE EMPLOYERS
(In Billions, 1990)

	Firms That Now Offer Insurance	Firms That Do Not Insure	All Firms
Current Employer Expenditures for Health Insurance ^a	\$115.5	—	\$115.5
Changes in Employer Costs			
Cost of Insuring Workers and Dependents Not Now Covered	6.6	13.0	19.6
Impact of Minimum Benefit and Premium Standards	4.8	--	4.8
Employer Premium Share Increase	3.8		
Improvement in Plan Provisions	1.0		
Insurance Assessment to Fund State Risk Pool Subsidies	5.5	0.7	6.2
Tax Credit to Small Employers	(0.1)	(1.2)	(1.3)
Cost Shift Savings	(10.2)	--	(10.2)
Total Employer Costs	122.1	12.5	134.6
Net Change in Employer Cost	6.6	12.5	19.1
Change in Corporate Income Tax	(1.7)	(3.2)	(4.9)
Supplemental Deductions for New Firms	(0.3)		
General Tax Deduction	(4.6)		
Net After-Tax Change in Employer Costs	4.9	9.3	14.2

^a Includes employer share of premium for workers, dependents, and retirees.

^b The plan provides a refundable tax credit which limits employer expenditures for health benefits in small firms not to exceed a specified percentage of payroll (assumed to be 15 percent).

^c New firms may deduct 150 percent of health benefits costs in first year and 125 percent in the second year.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 3

SOURCES AND USES OF FEDERAL FUNDS UNDER THE EMPLOYER MANDATE PROPOSAL IN 1991
(In Billions)

Sources of Funds		Uses of Funds	
Personal Income Tax Increase ^a	\$21.2	Federal Share of Medicaid Expansion	\$14.1
		Tax Credit for Small Employer Costs Over 15 Percent of Payroll ^b	1.3
		Supplemental Tax Deduction for New Firms ^c	0.3
		Medical IRA Tax Loss ^d	1.9
		Change in Corporate Tax Revenues ^e	4.1
		Impact on Other Federal Programs	(0.5)
		Federal Workers Health Benefits CHAMPUS Medicare	0.6 (0.9) (0.2)
Total Program Revenues	\$21.2	Total Program Costs	\$21.2

^a The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (4.3 percent).

^b Employers with 25 or fewer employees will receive a refundable tax credit for health expenditures in excess of a specified percentage of payroll (assumed to be 15 percent).

^c New firms are permitted to deduct 150 percent of employee health benefits costs in the first year and 125 percent of benefits costs in the second year.

^d Individuals are allowed to make tax deductible contributions to medical IRA's in the amount of \$500 per individual and \$1,000 per husband/wife couple.

^e Employers are assumed to absorb the cost of expansions in coverage in the form of reduced profits resulting in changes in corporate income tax deductions for health benefits and tax payments.

SOURCE: Lewin/ICF estimates using the Health Benefit Simulation Model (HBSM).

Table 6

**IMPACT OF THE EMPLOYER-MANDATE PROPOSAL
ON LOCAL GOVERNMENTS IN 1991**
(In Billions)

	Change In Expenditures
<i>Changes in Employee Benefit Costs</i>	\$2.1
<i>Savings to Public Hospitals and Other Programs^a</i>	(6.0)
<i>Net Impact on Local Governments</i>	(\$3.9)

^a Public hospitals that now serve indigent patients will be reimbursed for services provided to patients who become insured under the program resulting in savings to local governments.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 7

**IMPACT OF THE EMPLOYER MANDATE PROPOSAL ON
HOUSEHOLD HEALTH RELATED EXPENDITURES
IN 1991
(In Billions)**

		<i>Change From Current Policy</i>
Funding for Public Program		
<i>Premium Payments to State Risk Pool</i>		13.5
<i>Federal Taxes</i>		19.3
<i>Medical IRA's</i>	(1.9)	
<i>General Revenue Funding</i>	21.2	
<i>State Taxes</i>		8.6
Offsets to Tax Payments		
<i>Employee Share of Employer Plan Premiums</i>		(9.8)
<i>Non-Group Plan Premium Payments</i>		(12.3)
<i>Household Out-of-Pocket Expenditures</i>		(11.4)
Total Net Change		\$ 7.9

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

**THE ALL-PAYOR
HEALTH REFORM PROPOSAL:
ESTIMATED COST AND IMPACTS**

Prepared For:

The Social Security Advisory Council

Prepared By:

*Lewin/ICF
A Health and Sciences International, Inc.*

December 19, 1991

THE ALL-PAYOR MODEL

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EMPLOYER RESPONSIBILITY

- **EMPLOYERS MUST INSURE ALL EMPLOYEES AND DEPENDENTS WORKING 17.5 HOURS OR MORE PER WEEK.**
 - *A refundable tax credit is created which caps employer health expenditures to seven percent of employee payroll.*
 - *Firms with under 100 employees will be covered under government operated public plans.*
 - *Large firms (100 or more employees) will have the option of participating in the public plan.*
- **WORKING DEPENDENTS ARE REQUIRED TO TAKE COVERAGE ON THEIR OWN JOB.**
- **THE PLAN COVERS:**
 - *Inpatient and Outpatient Hospital Care*
 - *Physicians Services*
 - *Prescription Drugs*
 - *Laboratory and Diagnostic Tests*
- **EMPLOYERS HAVE THE OPTION OF SUPPLEMENTING THE BASIC BENEFITS PACKAGE.**
- **THE PUBLIC PLAN CAN ALSO OFFER A HIGHER OPTION PLAN TO BE PURCHASED OUT-OF-POCKET.**

EMPLOYER RESPONSIBILITY

(continued)

- **COST SHARING**

- **\$250 Deductible (\$500 Per Family)**
- **Out-of-Pocket Limit of \$2,000**

Coinsurance	Plan Provisions
Inpatient Hospital Services	80%
Outpatient Hospital Services	80%
Hospital Alternative (Extended or Home Health Care)	Yes
Physician Services	80%
Prenatal/Well Baby/Well Child-Care	100%
Diagnostic Tests	80%
Prescription Drugs	80%
Emergency Services	80%
Mental Health Care	Not Covered
Dental Care	Not Covered

- **EMPLOYER PAYS 80 PERCENT OF PREMIUM FOR BASIC BENEFITS PACKAGE**

PERSONS NOT COVERED BY AN EMPLOYER PLAN

- **PUBLIC PROGRAM ESTABLISHED TO COVER NON-WORKERS:**
 - *Includes persons working less than 17.5 hours per week*
 - *Medicaid subsumed into program*
- **COVERED SERVICES AND COST SHARING REQUIREMENTS ARE THE SAME AS UNDER THE EMPLOYER PLAN EXCEPT FOR LOW-INCOME FAMILIES.**
- **PREMIUM AND COST SHARING SUBSIDIZED FOR PERSONS BELOW 200 PERCENT OF POVERTY.**
 - *Premium and cost sharing eliminated for persons below poverty.*
 - *Premium and cost sharing phased-in between poverty and 200 percent of poverty.*
 - *All above 200 percent of poverty pay the full premium and cost sharing amounts.*

Figure 1
SUPPLEMENTAL BENEFITS FOR
PERSONS BELOW POVERTY

Benefits	Plan Provisions
Private Duty Nursing	100%
Dental Care	100%
Clinic Services	100%
Physical Therapy	100%
Occupational Therapy	100%
Speech, Hearing and Language Disorders	100%
Dentures	100%
Prosthetic Devices	100%
Eyeglasses	100%
Preventive Services	100%
Rehabilitative Services	100%
Inpatient Psychiatric Care for Individuals Under Age 21	100%
Hospice Services	100%
Transportation	100%
Case Management	100%
Early and Periodic Screening, Diagnosis, and Treatment for Individuals Under Age 21	100%
Podiatrists, Optometrist, and Chiropractor Services	100%

ADMINISTRATION

- **GOVERNMENT ADMINISTRATIVE AUTHORITY ESTABLISHED TO:**
 - *Select carriers to administer coverage*
 - *Develop and coordinate health policy*
 - *Assess quality and efficiency of statewide delivery system*
 - *Regional planning for the aquisition of new capital and technology*
 - *Negotiate with providers.*
- **EMPLOYERS AND NON-WORKERS WILL SELECT AN INSURANCE CARRIER FROM A LIST OF INSURERS APPROVED BY THE STATE:**
 - *Approved carriers will include HMO's and other organized systems of care.*
 - *Carriers will compete on the basis of price and quality.*
 - *Carriers will be required to accept all applicants.*
- **ALL CARRIERS WILL REIMBURSE PROVIDERS ON THE BASIS OF UNIFORM FEE SCHEDULES:**
 - *DRG and RBRVS reimbursement schedules used throughout the system.*
 - *Balance billing is eliminated.*
- **UNIFORM REIMBURSEMENT LEVELS ASSURE THAT ALL INDIVIDUALS HAVE EQUAL ACCESS TO CARE REGARDLESS OF INCOME OR SOURCE OF INSURANCE (I.E., ELIMINATE COST-SHIFTING).**

FINANCING

- **EMPLOYER CONTRIBUTIONS TO HEALTH INSURANCE PREMIUMS.**
- **EMPLOYEE CONTRIBUTIONS FOR HEALTH INSURANCE PREMIUMS.**
- **PREMIUM PAYMENTS BY NON-WORKERS (BASED ON ABILITY TO PAY).**
- **PERSONAL INCOME TAX PAYMENTS TO COVER THE COST OF SUBSIDIES TO LOW-INCOME FAMILIES AND EMPLOYERS OF LOW WAGE WORKERS:**
 - **Total increase in personal income taxes: \$36.1 billion**
 - **Personal income tax rates would be increased by 7.4 percent (e.g., the 28 percent marginal rate would increase to about 30 percent).**

COST CONTAINMENT

- **EXPENDITURE TARGETS ENFORCED THROUGH DRG's AND RBRVS RATE SCHEDULES TO ASSURE LONG-TERM COST CONTAINMENT.**
- **PROMOTE ECONOMIC DISCIPLINE IN HEALTH CARE MARKETS THROUGH COMPETING ORGANIZED SYSTEMS OF CARE.**
- **REGIONAL PLANNING FOR ACQUISITION OF CAPITAL AND TECHNOLOGY.**

ASSUMPTION

- **FOR ILLUSTRATIVE PURPOSES WE ASSUME THAT THE PER CAPITA GROWTH IN HEALTH SPENDING IS REDUCED BY TWO PERCENT PER YEAR UNDER THE EXPENDITURE TARGETS.**

Table 1

**CHANGE IN NATIONAL HEALTH SPENDING
UNDER THE ALL-PAYOR MODEL IN 1991
(In Billions)**

Household Payments		\$ 3.8
Tax Payments	36.1	
Premium Payments	(11.0)	
Out-of-Pocket Spending	(21.3)	
Private Employers		18.6
Currently Provide Insurance	0.7	
Currently Do Not Insure	17.9	
State and Local Governments		(10.5)
Federal Government (Program Fully Funded)		0.0
Change in National Health Spending		\$11.8
Utilization Increase for Newly Insured	12.2	
Net Change in Administrative Costs	(0.4)	

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 2
SOURCES AND USES OF FEDERAL FUNDS UNDER
THE ALL PAYOR MODEL IN 1991
(In Billions)

SOURCES OF FUNDS		USES OF FUND	
Premium Payments for Small Employers Covered Under Public Plan ^a	\$ 75.6	Benefit Payments	\$138.9
Employer Share	60.5	Small Employers Covered Under Public Program ^a	65.3
Employee Share	15.1	Non Workers Program ^a	
		Current Medicaid	40.4
		Newly Eligible	25.5
		Supplemental Benefits	7.7
Premium Payments for Non-Workers ^b	10.1	Administrative Costs ^a	10.1
		Workers and Dependents	7.9
		Non-Workers	2.2
State Contribution to Public Program ^c	17.7	Tax Credit for Employer Health Benefits Over 7.0 Percent of Payroll ^b	10.7
General Revenue Contribution ^d	36.1	Change in Corporate Tax Revenues ⁱ	6.1
		Offsets to Other Federal Programs	(26.3)
		Medicaid	(25.4)
		CHAMPUS and Other ^j	(0.9)
Total Sources of Funds	\$139.5	Total Uses of Funds	\$139.5

(Footnotes on Next Page)

Table 2

SOURCES AND USES OF FEDERAL FUNDS UNDER THE ALL-PAYOR MODEL

IN 1991

(In Billions)

Footnotes to Previous Table

- a Firms with under 100 employees would be covered under the public plan.
- b Individuals not otherwise covered under an employer plan can purchase insurance from the public sponsor by paying the premium. The premium is eliminated for persons below poverty and phased-in between poverty and 200 percent of poverty.
- c States are assumed to transfer to the program all funds currently used to finance the state share of Medicaid spending for acute care. Medicaid is assumed to be retained for long-term care.
- d The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (7.37 percent).
- e Workers covered under the public fund include workers in firms with under 100 employees.
- f Persons currently enrolled in Medicaid who do not become covered under an employer plan are transferred to the public plan (includes increased reimbursement for hospital and physicians care). Among newly eligible persons, the program pays cost sharing for all persons below poverty and phases in cost sharing through 200 percent of poverty. Includes the cost of supplemental benefits for persons below poverty.
- g Administrative costs are assumed to equal 12 percent of claims for the workers component of the program and 3.0 percent of claims for non-workers.
- i Employers are assumed to absorb the cost of expansions in coverage resulting in changes in corporate income tax deductions for health benefits and tax payments.
- h The plan establishes a refundable tax credit which limits employer expenditures for the minimum benefits package not to exceed 7.0 percent of payroll.
- j Includes the change in insurance cost for federal employees and CHAMPUS beneficiaries.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 2

**SOURCES AND USES OF FEDERAL FUNDS UNDER THE CONSUMER CHOICE MODEL
IN 1991
(In Billions)**

**Footnotes to Previous Table
(continued)**

- i* The program pays cost sharing for all persons below poverty and phases in cost sharing through 150 percent of poverty.
- j* Includes the cost of supplemental benefits for persons below poverty.
- k* Administrative costs are assumed to equal 12 percent of claims for the workers component of the program; 5.0 percent of claims for self-employed and others covered under the public plan; and 2.7 percent of the cost of subsidies to low income persons.
- l* Employers are assumed to absorb the cost of expansions in coverage resulting in changes in corporate income tax deductions for health benefits and tax payments.
- m* Includes the change in insurance cost for federal employees and CHAMPUS beneficiaries.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 3

IMPACT OF THE ALL-PAYOR MODEL ON PRIVATE EMPLOYERS

(In Billions, 1990)

	Firms That Now Offer Insurance	Firms That Do Not Insure	All Firms
Current Employer Expenditures for Health Insurance ^a	\$115.5	-	\$115.5
CHANGES IN EMPLOYER COSTS			
Cost of Insuring Part-Time Workers and Dependents	23.8	34.0	57.8
Impact of Minimum Benefit and Premium Standards Employer Premium Share Increase 3.4 Improvement in Plan Provisions 1.8	5.2	-	-
Working Spouses and Dependents Shifted to Other Employer Plans	(21.0)	-	21.0
7.0 Percent Cap on Employer Costs	(0.7)	(10.2)	(10.9)
Administrative Savings for Plans in Public Plan ^b	(1.2)	-	(1.2)
Retirees Covered Through Second Employer	(0.7)	-	(0.7)
Cost-shift Savings	(4.5)	-	(4.5)
Total Employer Costs	116.4	23.8	140.2
Net Change in Employer Costs	0.9	23.8	24.7
Change in Corporate Tax Expenditure Payment	(0.2)	(5.9)	(6.1)
Net After-Tax Change in Employer Costs	0.7	17.9	18.6

^a Includes employer share of premium for workers, dependents and retirees.

^b Assumes all firms with 100 or fewer workers enroll in the public plan.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

Table 4

**IMPACT OF THE ALL-PAYOR MODEL ON
STATE AND LOCAL GOVERNMENTS IN 1991
(In Billions)**

	Change in Expenditures
Changes in Employee Benefit Costs	\$(0.3)
Current Employee Benefit Costs 23.9	
Change in Employee Benefits Costs (0.3)	
Total Employee Benefit Costs 23.6	
Change in Medicaid Spending^a	0.0
Savings to Public Hospitals and Other Programs^b	(10.3)
Reduction in Corporate Tax Payments	0.1
Net Impact on State and Local Governments	\$(10.5)

a All funds currently allocated to the Medicaid program are assumed to be transferred to the public program.

b Public hospitals that now serve indigent patients will be reimbursed for services provided to patients who become insured under the program.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

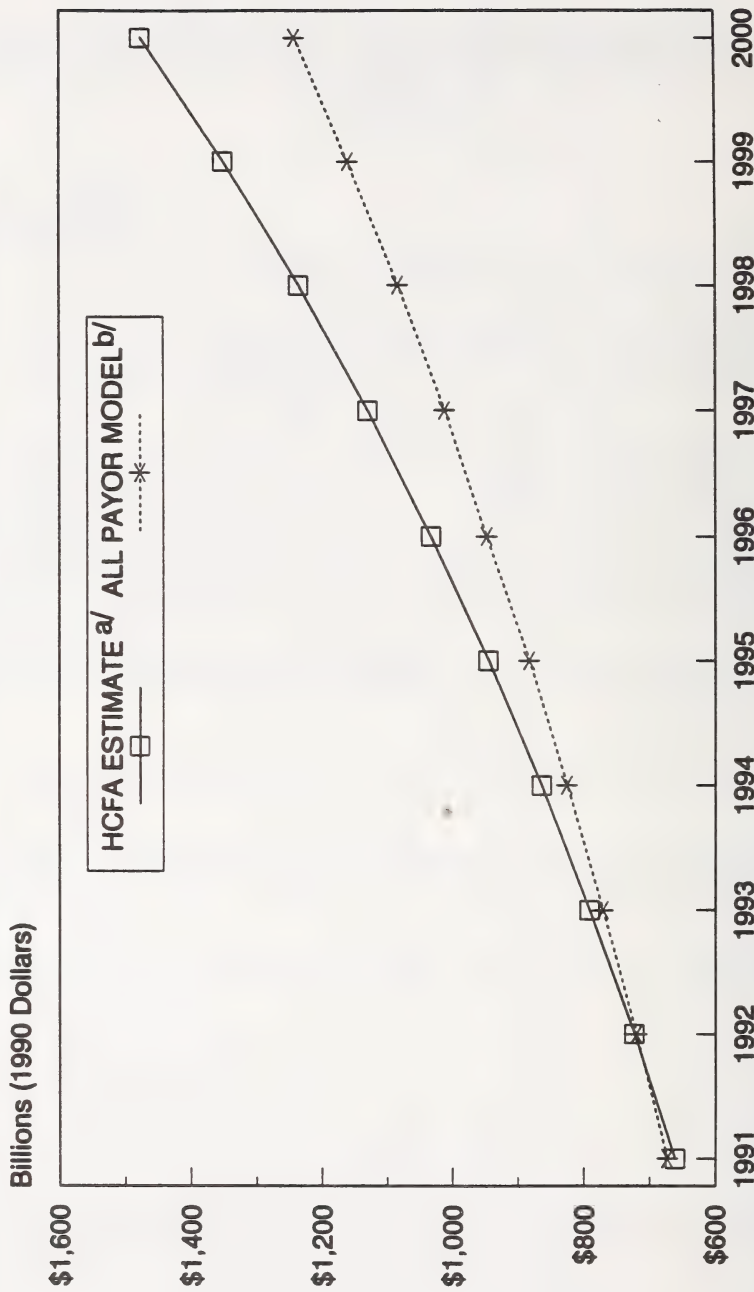
Table 5

**IMPACT OF THE ALL-PAYOR MODEL ON
HOUSEHOLD HEALTH RELATED EXPENDITURES IN 1991
(In Billions)**

	Change From Current Policy
Funding for Public Program	
Premium Payments for Non-Worker Program Participants	10.1
General Revenue Tax Payments to Fund Balance Program	36.1
Offsets to Tax Payments	
Employee Share of Employer Plan Premiums	(5.4)
Non-Group Plan Premium Payments	(15.7)
Household Out-of-Pocket Expenditures	(21.3)
Total Net Change	\$ 3.8

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

NATIONAL HEALTH SPENDING UNDER THE ALL PAYOR MODEL -- ILLUSTRATIVE PROJECTIONS 1991-2000



a/ HCFA estimates per capita health spending will grow 8.6 % annually between 1991 and 2000

b/ Assumes the annual growth in per capita health spending is slowed to 6.5% under the expenditure target system implemented by the All Payor Model

***THE PUBLIC HEALTH INSURANCE MODEL
FOR ACUTE CARE:
ESTIMATED COST AND IMPACTS***

Prepared For:

The Social Security Advisory Council

Prepared By:

Lewin/ICF

A Health and Sciences International, Inc.

December 19, 1991

THE PUBLIC HEALTH INSURANCE MODEL

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PLAN STRUCTURE

- ***ALL INDIVIDUALS ARE COVERED UNDER A NATIONAL HEALTH INSURANCE PLAN.***
- ***THE PLAN COVERS.***
 - *Inpatient and Outpatient Hospital Care*
 - *Physicians Services*
 - *Prescription Drugs*
 - *Laboratory and Diagnostic Tests*
 - *Mental Health and Substance Abuse*
 - *Prenatal/Well-baby/Child Care*
 - *Dental Care*
- ***NO COST SHARING FOR ACUTE CARE SERVICES.***
 - *Full First Dollar Coverage for All Services*
 - *No Copayments or Deductibles*

FINANCING

- ***THERE ARE NO PREMIUM PAYMENTS IN THE PUBLIC PLAN***
- ***A PAYROLL TAX OF 11.2 PERCENT IS ESTABLISHED TO COVER THE COST OF BENEFITS TO WORKERS AND DEPENDENTS***
 - *Employer Share of Payroll Tax is 80 Percent (9.0 Percent of Payroll)*
 - *Employee Share of Payroll Tax is 20 Percent (2.2 Percent of Payroll)*
- ***FUNDING FOR MEDICAID AND MEDICARE IS TRANSFERRED TO THE PUBLIC PROGRAM.***
 - *Federal Share of Medicaid*
 - *State Share of Medicaid*
 - *Medicare HI Payroll Tax Revenues*
 - *Medicare SMI General Revenue Contribution Transferred to Public Program*
- ***THE BALANCE OF THE PROGRAM IS TO BE FINANCED BY A COMBINATION OF STATE AND FEDERAL REVENUES WHERE THE FEDERAL MATCH RATE VARIES WITH THE ECONOMIC CHARACTERISTICS OF THE STATE.***
- ***FOR ILLUSTRATIVE PURPOSES, WE ASSUME THAT THE BALANCE OF THE PROGRAM IS FINANCED BY AN ACROSS THE BOARD INCREASE IN PERSONAL INCOME TAXES***
 - *Total Increase in Personal Income Taxes: \$48.9 billion*
 - *Personal Income Tax Rates Would be Increased by 10.0 Percent (e.g., the 28 Percent Marginal Rate Would Increase to 30.8 Percent); The Top Marginal Rate Would Increase From 31.5 Percent to 34.6 Percent).*

ADMINISTRATION/COST CONTAINMENT

- **HOSPITALS WOULD BE PLACED ON ANNUAL BUDGETS**
 - *Operating Budgets for Health Services*
 - *Capital Budgets for Facilities Expansion*
- **PHYSICIANS WOULD BE PAID ON A FEE-FOR-SERVICE BASIS**
 - *Uniform Fee Schedules*
 - *No Balance Billing*
- **COST CONTAINMENT IMPLEMENTED THROUGH GLOBAL BUDGETS**
 - *Hospital Operating Budgets*
 - *Physician Fee Schedules*
 - *Hospital Capital Budgets*

EMPLOYER RESPONSIBILITY

- ***EMPLOYERS WOULD NO LONGER OFFER HEALTH INSURANCE***
- ***EMPLOYERS WOULD PAY A TAX EQUAL TO 9.0 PERCENT OF EMPLOYEE PAYROLL (SEE FINANCING SECTION ABOVE)***
- ***SAVINGS IN EMPLOYER HEALTH INSURANCE PREMIUM COSTS IN EXCESS OF THE EMPLOYER PAYROLL TAX WOULD BE PASSED ON TO EMPLOYEES IN THE FORM OF INCREASED WAGES AND SALARIES***

Table 1

**CHANGE IN NATIONAL HEALTH SPENDING
UNDER THE PUBLIC HEALTH INSURANCE MODEL
IN 1991
(In Billions)**

Household Payments		\$(54.5)
Tax Payments	117.9	
Premium Payments	(85.1)	
Out-of-Pocket Spending	(87.3)	
Private Employers		92.8
Currently Provide Insurance	42.8	
Currently Do Not Insure	50.0	
State and Local Governments		(14.5)
Federal Government^a		0.0
Increase in Federal Spending	394.1	
Additional Federal Revenues (offset)	(394.1)	
Net Change in National Health Spending		\$23.8

a The program specifies revenue raising measures which are sufficient to cover projected program costs.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 2

**SOURCES OF CHANGES IN NATIONAL HEALTH
SPENDING UNDER THE PUBLIC HEALTH INSURANCE
MODEL IN 1991
(In Billions)**

CHANGE IN EXPENDITURES	
SAVINGS IN ADMINISTRATIVE EXPENSES	
<i>Insurer Administrative Cost^a</i>	<i>\$(15.4)</i>
<i>Hospital Claims Filing Costs^b</i>	<i>(10.8)</i>
<i>Physician Billing Costs^c</i>	<i>(1.2)</i>
CHANGES IN UTILIZATION	
ACUTE CARE	
<i>Increased Utilization for Newly Insured Persons</i>	<i>12.2</i>
<i>Increase in Utilization Due to Elimination of Cost Sharing</i>	<i>39.0</i>
NET CHANGE IN HEALTH SPENDING	\$23.8

(Footnotes on Next Page)

Table 2

**SOURCES OF CHANGES IN NATIONAL HEALTH
SPENDING UNDER THE PUBLIC HEALTH INSURANCE
MODEL IN 1991**

(Footnotes to Previous Page)

- a Insurer administrative costs under the current system are about \$30.7 billion (administrative costs as a percentage of claims are 11.7 percent for private insurance and 2.7 percent for public programs). Administrative costs under the public program are estimated to be about \$15.3 billion (2.5 percent of claims) resulting in net savings of \$15.4 billion.*
- b Under the Public Health Insurance plan hospitals will be funded through annual operating budgets. The budgeting model eliminates the need for claims filing by hospitals resulting in administrative savings estimated to be \$10.8 billion.*
- c Balance billing is eliminated resulting in savings in physician administrative costs of \$1.2 billion.*
- d Utilization of health services for previously uninsured person is assumed to adjust to the level reported by insured persons with similar characteristics under the universal coverage model.*
- e We assume that utilization will increase by 10 percent for persons who were previously covered in plans with cost sharing. This assumption is based upon studies indicating that utilization is roughly 10 percent higher for persons in plans without cost sharing than among persons in plans with cost sharing.*
- f Most long-term care is currently provided informally by family members. We assume that much of this care will now be provided by health professionals. We assume that nursing home enrollment will increase by 30 percent and that utilization of paid home health services will increase by 100 percent.*

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

Table 3
SOURCES AND USES OF FEDERAL FUNDS
UNDER THE PUBLIC HEALTH INSURANCE MODEL IN 1991
(In Billions)

SOURCES OF FUNDS		USES OF FUNDS	
PAYROLL TAX PAYMENTS ^a		BENEFITS PAYMENTS	\$526.4
Employer Share	276.2	Acute Care	336.9
Employee Share	69.0	Workers and Dependents	189.5
		Non Workers	
MEDICARE HI PAYROLL TAX SHIFTED TO PROGRAM ^b		Administrative Costs ^c	13.2
STATE CONTRIBUTION TO PUBLIC PLAN ^d		Change in Corporate Tax Revenue ^e	28.5
PERSONAL INCOME TAX INCREASE ^d		Offsets to Other Federal Programs	(70.7)
		Medicaid (Federal Share)	25.4
		Medicare (General Revenue Portion) ^f	39.8
		CHAMPUS and Other ^g	2.5
TOTAL PROGRAM REVENUES	497.4	TOTAL PROGRAM EXPENDITURES	\$497.4

(Footnotes on Next Page)

Table 3

**SOURCES AND USES OF FEDERAL FUNDS
UNDER THE PUBLIC HEALTH INSURANCE MODEL IN 1991**

(Footnotes From Previous Page)

- a* A payroll tax of 11.2 percent is established to cover the cost of insuring workers and dependents of which 80 percent is paid by the employer and 20 percent is paid by the employee.
- b* The Medicare HI portion of the FICA payroll tax is transferred to the program.
- c* States are assumed to transfer to the program all funds currently used to finance the state share of medicaid spending.
- d* The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (22.4 percent).
- e* Administrative costs are assumed to be equal to 2.5 percent of benefit payments. This assumption is based upon Medicare program administrative data adjusted for the elimination of hospital claims filing.
- f* Employers are assumed to absorb the cost of expansions in coverage resulting in changes in corporate income tax payments.
- g* General revenue contributions to the Medicare SMI program are eliminated.
- h* Includes the change in insurance cost for federal employees and CHAMPUS beneficiaries.

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

Table 4
CHANGE IN PRIVATE EMPLOYER SPENDING UNDER
THE PUBLIC HEALTH INSURANCE MODEL IN 1991
(in Billions)^a

	<i>Firms That Now Offer Insurance</i>	<i>Firms That Do Not Insure</i>	<i>All Firms</i>
<i>Current Employer Expenditures for Health Care</i>	\$115.5	--	\$115.5
<i>Employer Payroll Tax</i>	172.6	66.7	239.3
<i>Elimination of Employee Coverage</i>	(105.7)	--	(105.7)
<i>Retirees Covered Under Public Plan</i>	(9.8)	--	(9.8)
<i>Total Employer Cost</i>	172.6	66.7	239.3
<i>Net Change in Employer Cost</i>	57.1	66.7	123.8
<i>Change in Tax Payments</i>	(14.3)	(16.7)	(31.0)
<i>Net After-Tax Change in Employer Costs</i>	\$42.8	\$50.0	\$92.8

^a Increases in employer costs under the program are assumed to be absorbed by employers in the form of reduced profits resulting in a loss of corporate income tax payments.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 5

**IMPACT OF THE PUBLIC HEALTH
INSURANCE MODEL ON STATE AND
LOCAL GOVERNMENTS IN 1991**
(In Billions)

	<i>Change in Expenditures</i>
Changes in Employee Benefit Costs	\$5.5
Elimination of Employer Plan (23.9)	
Payroll Tax Payments 29.4	
Change in Medicaid Spending^a	0.0
Contribution to Public Plan 19.9	
Medicaid Spending (19.9)	
Savings to Public Hospitals and Other Programs^b	(22.4)
Reduction in Corporate Tax Payments	2.5
Net Impact on State and Local Governments	\$(14.5)

a All funds currently allocated to the Medicaid program are assumed to be transferred to the public program.

b Public hospitals that now serve indigent patients will be reimbursed for services who become insured under the program.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 6

**CHANGE IN HOUSEHOLD HEALTH SPENDING UNDER
THE PUBLIC INSURANCE MODEL IN 1991
(In Billions)**

	Change From Current Policy
Individual Premium Payments	
<i>Employee Premium Payments</i>	(42.5)
<i>Medicare Part-B Premium Payments</i>	(12.4)
<i>Non-Group Premium Payments</i>	(30.2)
Tax Payments	
<i>Employee Share of Payroll Tax</i>	69.0
<i>Personal Income Tax Payments</i>	48.9
Direct Payments for Care	
<i>Households Out-of-Pocket Expenditures</i>	(128.1)
Net Change in Household Health Spending	\$(19.7)

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

COST CONTAINMENT

- **HOSPITAL AND NURSING HOME BUDGETS**

- *Hospital operating budgets could be used to limit growth in hospital spending*
- *Capital budgeting could limit the growth in hospital and nursing home utilization*

- **GLOBAL BUDGETING FOR HEALTH CARE EXPENDITURES TO LIMIT THE GROWTH IN HEALTH SPENDING**

- **ILLUSTRATION OF POTENTIAL IMPACTS**

- *Scenario 1 in the Initial Year Hospital and Nursing Home Budgets are Constrained so That Hospital and Nursing Home Utilization Does Not Increase Above the Level Expected Under Current Law plus an allowance for increased utilization among previously uninsured person.*
- *Scenario 2 Expenditure Targets are Set Which Limit the Growth in Per Capita Health Spending to 6.5 Percent Per Year (Per Capita Spending is Projected to Grow by 8.6 Percent Per Year Through 2000 Under Current Law).*

Table 7

SCENARIO 1

**ILLUSTRATION OF THE POTENTIAL
IMPACT OF HOSPITAL AND NURSING HOME BUDGETING
ON INITIAL YEAR NATIONAL HEALTH SPENDING IN 1991
(In Billions)**

	<i>Unconstrained Growth in Health Spending</i>	<i>No Growth in Hospital or Nursing Home Spending Permitted^a</i>
<i>Changes in Health Services Utilization</i>	51.2	34.2
<i>Administrative Savings^b</i>	(\$27.4)	(\$27.4)
<i>Net Change in National Health Spending</i>	\$23.8	\$ 6.8

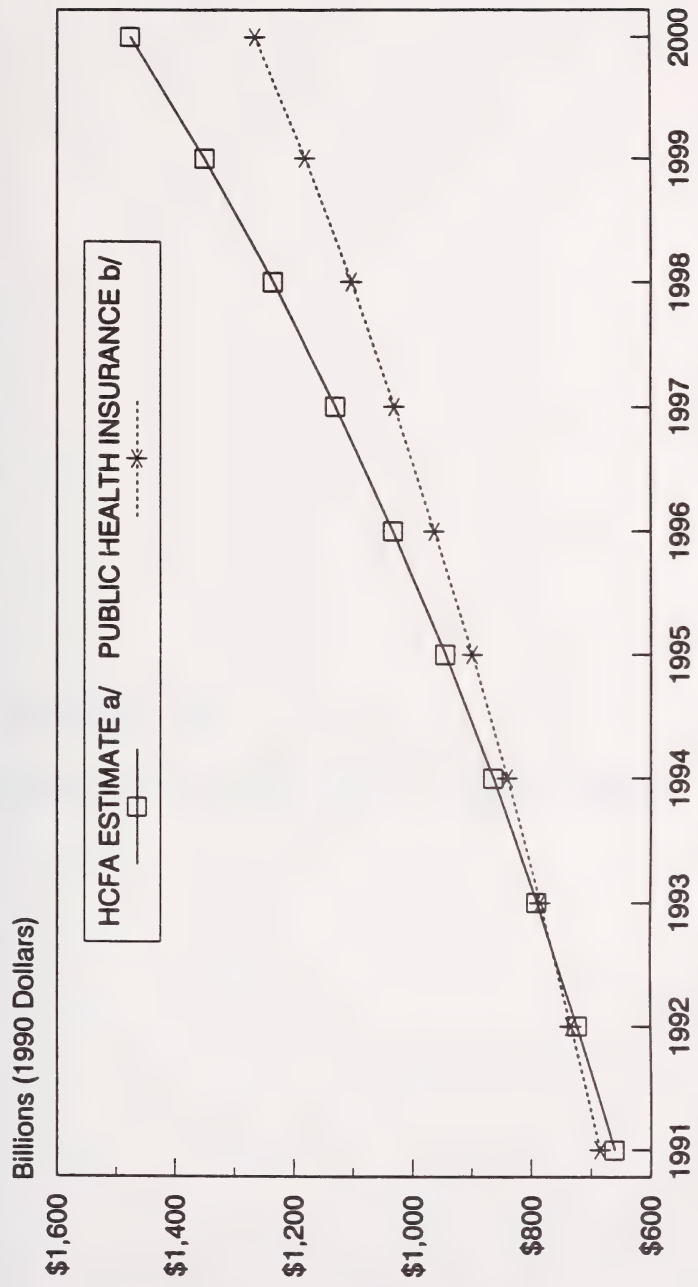
a In this scenario, capital and operating budgets are assumed to be constrained so that spending for hospital and nursing home services does not increase above the level projected under current law.

b Includes savings in both insurer and provider administrative costs.

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulator Model (HBSM).*

NATIONAL HEALTH EXPENDITURES UNDER THE PUBLIC HEALTH INSURANCE MODEL FOR ACUTE CARE

ILLUSTRATIVE PROJECTIONS, 1991-2000



a/ HCFA estimates per capita health spending will grow 8.6% annually between 1991 and 2000

b/ Assumes the annual growth in per capita health spending is slowed to 6.5% under the expenditure target system implemented by the public health insurance plan

Source: Lewin/ICF estimates

Appendix D:

Prototype Medicare Reforms

***OPTIONAL MEDICARE COMPREHENSIVE
COVERAGE PLAN***

Prepared For:

The Social Security Advisory Council

Prepared By:

***Lewin/ICF
A Health and Sciences International, Inc.***

December 19, 1991

OPTIONAL MEDICARE COMPREHENSIVE COVERAGE PLAN

The current system of health care delivery and finance is complicated and confusing for many elderly and their families. The different covered services, reimbursement methods, claims payments, and cost sharing requirements under Medicare, Medigap, and Medicaid make even the smallest illness or routine checkup a nightmare of paperwork and negotiation. In addition, the lack of available coverage for prescription drugs and most home and long term care services leave the elderly and their families unable to protect themselves against these costs. These costs often outstrip the costs of hospitalization, yet Medicare does not cover them. This inconsistent coverage creates a very real economic threat for any family's financial security.¹

Elected officials and other concerned policy makers have struggled over how to eliminate this financial threat without raising taxes on today's workers or retirees or without further exacerbating the federal deficit. This proposal offers a way to organize a partnership between private insurance coverage and public insurance coverage to cover these gaps without increasing public expenditures.

In addition, this voluntary approach would provide a simple, comprehensive, and predictable method of health care delivery and financing for the elderly that removes both the complexity and the unpredictability caused under current law. The program would be comprehensive because it would cover acute care hospital and physicians services, prescription drugs, vision, dental, and long term care services in the home and in nursing homes. It would be simple because all of these benefits would be covered under one program, rather than the current set of multiple programs. And because this program would be entirely voluntary, beneficiaries could decide what plan works best for them, the current Medicare and Medicaid programs, or this more comprehensive proposal. To distinguish between these two choices, this program will be referred to as Medicare-Comprehensive.

¹ Economic insecurity occurs because most elderly families have some prescription drug expenses each year. Also, approximately 20 percent of 65 year olds in 1990 will spend one year or more in a nursing home before their death. At an average cost of \$30,000 per year, the threat of uncovered long term care expenses is significant.

Under Medicare-Comprehensive, the elderly and their families would no longer have to fear bankruptcy because they become afflicted with Alzheimers' disease instead of heart disease. Therapies for illnesses that require long term care services would be covered as well as illnesses that require acute care treatment. By eliminating the risk of catastrophic costs regardless of the type of illness, the elderly and their families would be able to better plan for their health care expenses. This would eliminate the biggest economic fear for many elderly.

Medicare-Comprehensive is a program that would consist of a specifically defined partnership between private insurance (or self-insurance) and public coverage. Medicare-Comprehensive would offer a comprehensive set of benefits and would require that the same set of services covered by the government program would also be covered by private insurers. A private insurance plan would cover initial medical expenses up to a specified expenditure cap, after which the government program would pay all further medical costs. The public plan would cover all medical expenses for beneficiaries who exceed the private cap. By establishing a cap on private out-of-pocket payments, the risk of catastrophic health care costs, whether due to hospitalization or prolonged home care would be eliminated.

Individuals would pay premiums and (if applicable) co-payments and deductibles to finance the private coverage; today's Medicare payroll tax would remain in place to finance the government expenditures.

A. PUBLIC RESPONSIBILITY

1. Benefits

The first goal of this proposal is to provide comprehensive coverage. The federal government would determine the benefit package. The medical services covered under this program would include all current Medicare services along with additional prescription drug, dental, vision, hearing, and long term care services. The benefits are outlined in Exhibit 1. Medical services not covered by the program, but which may be offered as supplements to basic insurance packages, would be social services (i.e., home care services needed by lesser impaired individuals).

EXHIBIT 1
BENEFIT PACKAGE

Inpatient Hospital Services
Outpatient Hospital Services
Physician Services
Diagnostic Tests
Prescription Drugs
Vision Services
Hearing Service
Dental Services
Home Health Care
Skilled Nursing Facility Stays
Intermediate Care Facility Stays
Hospice Care
Rural Health Clinic Services
Physical and Speech Therapy
Home Dialysis Supplies & Equipment
Artificial Devices

2. Financing

Under this proposal, the federal government would cover non-routine expenses and the individual would buy private insurance for routine care. The federal plan would reimburse beneficiaries for covered expenses above a specified dollar amount in medical and/or long term care expenses. There would be three possible public threshold triggers to account for the differing potential financial burdens of various illnesses:

Exceeding a lifetime expenditure cap for medical expenditures after age 64 (e.g., \$120,000). This trigger is designed to assist beneficiaries who accumulate significant expenditures for health care that over time become a hardship.

- Exceeding an average expenditure cap over a specified period after age 64 (e.g., \$20,000 a year for three years). This trigger is designed to assist beneficiaries with chronic and persistent large expenses.
- Exceeding a high one-year expenditure cap after age 64 (e.g., \$35,000 in one year). This trigger is designed to assist beneficiaries with large expenses associated with a high-cost catastrophic event.

Basing one of the public financing thresholds on lifetime expenses after age 64 would ensure that Medicare beneficiaries would not suffer cumulative catastrophic health care costs. Basing another public threshold on a three year average of health care expenditures would ensure that younger beneficiaries who have chronic diseases (and also who may live another twenty years), would receive coverage prior to costs becoming catastrophic. Finally, a public threshold based on catastrophic one-year expenses would protect beneficiaries with intensive acute care needs as well as those who require long term nursing home care.²

The government program would be financed by estimating the level of government funds spent for Medicare and Medicaid on a per capita basis for individuals after age 64. For each individual who elects to enter the program, this amount of funds would be made available to the program. This level of funds would cover not only government payments for health care expenditures above the private cap, but it would also pay for premium subsidies for lower income elderly.

Over time, the private cap would be adjusted for new cohorts of enrollees. For example, the private expenditure cap might be \$120,000 in lifetime expenditures for persons who enrolled in 1992. For persons who enrolled in 1993, the cap might be \$125,000. The cap would increase each year.

Under this program, the federal government would reimburse providers directly for services delivered to beneficiaries who have exceeded the private cap. The government

² In order to curb potential inappropriate utilization under the third trigger (a one-year expenditure cap), it may be advisable to include a deductible in the following year that would be partially or fully refunded as medical expenditures exceed certain limits. For example, after \$35,000 in medical expenditures in the first year, a person would be required to pay a \$2,500 deductible of which one dollar would be refunded for each dollar of medical expenses in the second year that exceeds \$4,000. Thus, a person with expenditures of \$6,500 in the second year would have no deductible.

would conduct case management for persons who exceeded the private cap to ensure that high quality, cost effective services were offered.³ The case management services would also ensure that services were appropriately utilized.

For persons who enter this program, the Medicaid program would no longer be necessary. The need to "spend-down" to Medicaid would be eliminated. Medicaid would continue to cover eligible Medicare beneficiaries who did not choose this program, and even for those who choose to enter the program, Medicaid programs would offer non-covered services, such as social-service based long term care services to eligible Medicare beneficiaries.

2. Contributions and Cost Sharing

Beneficiaries in this program would be responsible for either self-insuring or buying private insurance for the amount under the spending cap. Insurers under this program could offer premiums which remain fixed in nominal dollars over time, premiums that increase at a pre-specified level, or both. The role of the federal government would be to provide assistance with premiums for low-income elderly families by providing tax credits for the purchase of insurance. The tax credit would pay the entire premium for persons under the poverty level and would be phased out at higher income levels.

B. INDIVIDUAL RESPONSIBILITY

Individuals would have the option of electing to participate in the Medicare Combined Acute/Long Term Care Coverage program at age 60 or earlier, with benefits beginning at age 65. Participation in the program would be entirely voluntary. Requiring individuals to choose between the traditional Medicare program and the combined program at age 60 or younger would reduce adverse selection and would lower the premium cost to the enrollee.

³ The government would probably contract for these services with private organizations. In fact, to encourage case management from the start, the government might decide to contract with the private insurer's case manager.

Participants would purchase private insurance (or self insure) to cover expenses below the specified dollar threshold. Premiums would be based on the cost to insurers for providing reimbursement for services up to the threshold. Premiums for each cohort of purchasers would be based on the age of initial purchase and would not increase above specified levels over time.⁴ There would be no pre-existing condition clauses. Insurers would have to charge the same premium to all persons of the same age.

Insurers would be required to have open enrollment periods for beneficiaries at the start of the program and for those who subsequently turn age 60, during which medical underwriting would be prohibited. Insurers would also offer open enrollment at younger ages. Allowing earlier entrants would not only further reduce adverse selection, but it would also allow individuals and employers to pre-fund the cost of the plan. This would allow employees to negotiate with employers to dedicate employer retiree health contributions toward their selection of Medicare-Comprehensive. It would be desirable, under this earlier pre-funding, to allow employers to receive a tax deduction for their pre-funded contributions to this arrangement.

Insurers could offer HMO or fee-for-service options for different premiums. The comprehensive service package described above would be determined by the federal government, and insurers would have to offer the same benefits. Private expenditure caps for individuals would vary based on the service delivery/reimbursement option selected (HMO or fee-for-service in combination with government reimbursement rates or insurer-specified reimbursement rates). The potentially lower level of the private caps of the systems that require more managed care would provide an incentive for participants to elect these coverage options.

As discussed above, the federal government would require a uniform package of services (i.e., inpatient and outpatient care, home care, nursing home care, and pharmaceuticals) to be covered. The NAIC, along with states, would continue to regulate insurers participating in this arrangement. Deductibles and copayments/coinsurance would be encouraged, but not mandated. Supplemental private plans also could be marketed, but

⁴ Some insurers would offer fixed nominal dollar premiums while others would offer premiums which were lower at the beginning, but increased each year.

only to cover services not included in the comprehensive service package (e.g., social service-based long term care).

Participants would be permitted to switch among insurers and plan options. A participant choosing to switch insurers, though, would be required to pay a higher premium rate. Charging higher premiums should discourage "switchers" from changing plans to avoid risk pooling because these persons are likely to be candidates for creaming by insurance companies. Participants would also be permitted to return to the traditional Medicare reimbursement system, although at an increased premium and cost sharing.

For beneficiaries who elect this approach, insurance purchase would not be mandatory. Persons who do not purchase insurance and have large medical bills would be required to pay for services until they spent down to Medicaid.

C. EMPLOYER RESPONSIBILITY

Under this approach, employer responsibility would be limited to two decisions: whether to provide retiree health benefits, and if so, to provide such benefits under current law or to help employees toward participating in the comprehensive structure of Medicare-Comprehensive. Due to the unpredictable increases in health care costs and a new accounting standard, known as FASB-106, many employers are reconsidering their decision to provide retiree benefits. This proposal offers an environment in which such a decision would be less desirable.

With the mandate from the Financial Accounting Standards Board (FASB 106)⁵ to recognize future retiree health costs, many employers are expected to move from "defined benefit" style health plans (where future costs are a function of unknown increases in medical prices) to defined contribution style plans (where the employer promises to provide a specified level of funding to the retired employee and the employee may use the funding to finance health care services as he or she pleases). Such changes in retiree health plans will

⁵ Specifically, the standard would move accounting for retiree health plans from a pay-as-you-go or cash basis to an accrual basis, thereby significantly increasing the reported expense for these benefits and creating an accrued liability on corporations' financial statements.

stabilize the impact of retiree health benefits on corporations, and will encourage employees to prefund for retiree health benefits. A plan in which a guaranteed, specified level of health care can be pre-funded, such as in this proposal, would benefit both employers and employees with retiree health plans.

Under Medicare-Comprehensive, employers could finance partially or entirely the premium costs of the private insurance coverage in a "defined contribution" context. In so doing, they would remove the specter of catastrophic costs for themselves and their current workforces just as those same fears would be removed from the beneficiaries themselves under the Medicare-Comprehensive plan.

D. PROVIDER REIMBURSEMENT

Private health insurers would be permitted to reimburse providers in any manner that they wish (i.e., based on charges, or the lesser of charges and DRG rates or physician fees). Insurers would be allowed to use the Medicare reimbursement system to pay providers if they so elected.

E. COST CONTAINMENT

Cost containment under the private cap would be the responsibility of insurers and individuals. A desire to increase market share and to control costs would provide the incentive for instituting cost containment measures. Expenditure thresholds would be established by the federal government for each cohort entering eligibility for the benefits. The assumptions used in calculating the thresholds are a key cost containment incentive in that the level of medical inflation assumed dictates the threshold and in turn influences the premiums charged by private insurance. Insurers would thus have an incentive to keep cost increases below the inflation assumptions built into the thresholds.

F. QUALITY

Patients would be referred to designated "Centers of Excellence" to receive Medicare reimbursement for some conditions (e.g., bone marrow transplants, CABGs, hip replacements, and cataract surgery). This program of directed care would promote both

quality of care and cost containment. The continuity of care permitted under a directed and coordinated system of care with early case management would both contain costs and promote the provision of effective services of high quality.

G. EXPECTED COSTS

Preliminary estimates indicate that the expenditure thresholds under the program for the cohort of individuals who turned age 65 in 1986-90 would be:

- a lifetime threshold of \$120,000; or
- a 3-year average threshold of \$60,000 (i.e., \$20,000 a year for three years); or
- a 1-year threshold of \$35,000.

All of these dollar limits are in constant 1989 dollars. Note that if a participating individual exceeds any one of these thresholds, he or she will receive benefits from the program.

These thresholds are based upon the assumption that the program will be funded with the amount of Medicare dollars that would have been spent on this cohort along with the Federal portion of expected Medicaid expenditures for these persons. These estimates assume there would be no adverse selection and that the program would subsidize the private insurance premiums for low income elderly. Specifically, the program would pay the following share of the expected premium for persons at various income levels:

- 100% for persons below the poverty level; and
- 50% for persons with incomes between 100 and 200 percent of the poverty level.

The expected cost of providing insurance for health care expenditures under the threshold was estimated in constant 1990 dollars. The following table presents premiums when funding starts at age 40, age 50, age 60, and age 65, for two different plans. Both plans assume a yearly cap of \$35,000, a three year cap of \$60,000, and a lifetime cap of \$120,000, but with two different cost-sharing systems: 1) the more expensive plan has a deductible of \$200 and 20 percent coinsurance on the next \$4,000 (a total possible cost-sharing of \$1,000); and 2) the less expensive plan also has a \$200 deductible, but the 20 percent coinsurance is incurred on expenses up to the cap.

MONTHLY PREMIUMS UNTIL DEATH

Age When Premium Starts	Expensive Plan's Premiums per Month	Cheaper Plan's Premiums per Month
40	\$85.00	\$78.00
50	\$131.00	\$120.00
60	\$228.00	\$210.00
65	\$350.00	\$322.00

These premiums are for an average cohort turning age 65 between 1986 and 1990. In some sense, this is a calculation of what "might have happened" if this cohort could have selected this program.

Appendix D:

Prototype Medicaid Reforms

Demonstrations

1. Improving Access to Medicaid Services

The Problem

The Medicaid program provides health care services to approximately 27 million Americans. However, it has long been recognized that Medicaid beneficiaries in many areas of the country are unable to gain access to providers, including physicians, home health services, nursing services and others types of providers, who will accept Medicaid. This often drives Medicaid beneficiaries into emergency room settings to receive care that could be better and more efficiently delivered in other settings. The most frequently cited access problems are: (1) access to almost all services in inner cities, and (2) access to particular physician specialties, such as OB/GYNs, especially in rural areas.

What is causing these access problems? A popular hypothesis is that the major factor causing these access problems is the very low Medicaid reimbursement rates that exist in the vast majority of states. In spite of the recognition of this problem, State budget constraints have prevented states from raising statewide rates. Medicaid statutory requirements also tend to make it difficult for Medicaid programs to target sub-areas of the state or particular groups of providers with special reimbursement rates.

Access Demonstrations

The Council recommends that legislation be developed that will permit a series of demonstrations of the effect of increasing Medicaid provider reimbursement rates on Medicaid beneficiary access to care. The following two types of demonstrations are designed to provide data and experience on specific ways in which provider rates may be changed to increase access to care.

Demonstrations Targeted to Medically Underserved Areas

Access to care for Medicaid beneficiaries is a particular problem in rural areas. However, according to Bureau of the Census, approximately 71 percent of the population of all rural areas are within 100 miles of at least one urban area. The first set of demonstrations will examine what changes in the reimbursement system would be necessary to entice physicians and other providers to provide services in rural areas. For example, could rates to OB/GYN physicians be increased in such a way as to allow clinics or offices for one or two days a week in a rural area adjacent to their urban area? This demonstration would allow the Secretary of Health and Human Services(HHS) to waive all necessary statues and regulations to conduct such demonstrations. States would be required to apply to the Secretary for approval and agree to:

- Participate in an independent evaluation of the demonstration conducted by a contractor selected by the Secretary,
- Guarantees to be specified by the Secretary regarding the quality of care provided by the demonstration providers, and
- Accept outlay limitations negotiated as part of the application process. Above these limitations, States would be liable for outlays.

The Secretary would be responsible for monitoring the demonstrations and reporting regularly on their progress.

Site Selection

Two types of areas would be eligible for demonstrations.

1. Primarily Rural Sites

First, are areas which the state can document do not have adequate numbers of providers either who will accept Medicaid patients. The Secretary will generally define such areas using the guidelines currently existing for medically underserved areas. However, the Secretary may tailor these requirements to Medicaid program circumstances. At least one half of these demonstrations will be in rural areas.

The primary hypotheses to be tested in these sites are:

1. If reimbursement is raised to an adequate level, physicians and other providers in urban areas, adjacent to rural areas with access problems, will set up full or part-time offices or clinics in the rural areas.
2. If reimbursement is raised to an adequate level, physicians and other providers in rural areas who are currently not serving Medicaid beneficiaries will begin serving them.

Other hypothesis suggested by the states or the Secretary will be tested at the discretion of the Secretary.

2. Primarily Urban Sites

The second type of site for the demonstrations will be an area where the state can demonstrate that Medicaid beneficiaries are overutilizing emergency room and similar services. Rather than primary care Providers. At least one half of these demonstrations will be in urban areas.

The primary hypothesis to be tested in these areas are:

1. If reimbursement is raised to adequate levels, physicians and other providers who are not serving Medicaid beneficiaries will begin serving them.
2. The cost of raising physician and other provider reimbursement will be more than offset by decreased costs in emergency room and other settings. Hence, there will be net savings to the Medicaid program from raising selected reimbursement rates.

Increased Federal Match for Increased Reimbursement Rates

States may increase reimbursement rates in these areas up to 150 percent of current Medicaid rates or 125 percent of usual and customary fees, whichever is greater. The dollar difference between current Medicaid reimbursement rates and the demonstration rates will be matchable at 90 percent federal funds.

Evaluation

The Secretary shall select an independent contractor to monitor and evaluate the demonstrations. As part of the contractor's final report, the contractor will examine the costs and/or savings of increasing rates in all states.

Demonstration Costs

The Secretary shall award up to \$400 million per year in federal monies for the demonstration and an additional \$3 million for the evaluation contractor. If the demonstration sites have typical per capita costs, this would mean that approximately 450,000 persons annually currently not receiving services would receive them through the demonstrations. These costs assume that increased access to physicians in demonstration areas will (1) increase Medicaid beneficiary access to other needed services such as hospital, diagnostic and other services and (2) induce some persons in rural areas eligible for the Medicaid program to enroll.

Estimate

Table D-1

**ESTIMATE OF THE COST OF
DEMONSTRATION TO IMPROVE ACCESS TO MEDICAID SERVICES:
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Demonstrations	200	400	400	1000
Evaluation Contractor	3	3	3	9
TOTAL	203	403	403	1009

2. Outreach Demonstrations

The Problem

Community Health Centers (CHCs), Migrant Health Centers (MHCs), and the Medicaid program fail to reach a number of populations that are in need of, and eligible for, health care services. For example, although data are not available to answer the question definitively, as many as 7 million of the uninsured may be eligible for, but not enrolled in, the Medicaid program. Similarly, several million poor or nearly poor pregnant women do not receive medical attention until the third trimester. The reasons for these and other eligible persons not receiving necessary services are varied and not well understood.

The Demonstrations

States, CHCs and MHCs will be authorized to spend up to \$50 million dollars on outreach activities. New eligibles identified by the outreach activities would be matchable for the first two years of eligibility at 90 percent federal dollars.

These CHCs, MHCs and State Medicaid programs will be allowed to target groups in need of services and employ a variety of outreach activities designed to encourage eligible persons to receive needed services. Some of the types of outreach whose effectiveness in reaching target groups will be tested include:

1. The effectiveness of media based campaigns,
2. The effectiveness of local non-profit organizations, and
3. The effectiveness of personal canvassing activities.

Other types of outreach identified by the state or the Secretary will also be examined at the discretion of the Secretary.

The Secretary of Health and Human Services(HHS) shall waive all necessary statutes and regulations to conduct such demonstrations. CHCs, MHCs and States would be required to apply to the Secretary for approval and agree to:

- Participate in an independent evaluation of the demonstration conducted by a contractor selected by the Secretary,
- Guarantees to be specified by the Secretary regarding the quality of care provided by the demonstration providers, and

- Accept outlay limitations negotiated as part of the application process. Above these limitations, States would be liable for outlays.

The Secretary would be responsible for monitoring the demonstrations and reporting regularly on their progress.

Evaluation

The Secretary shall select an independent contractor to monitor and evaluate the demonstrations. As part of the contractor's final report, the contractor will estimate the number of persons that could be reached by the approaches employed in the demonstrations and the cost thereof if they were employed nationwide and the associated costs.

Demonstration Costs

The Secretary shall award up to \$350 million per year for the demonstration and an additional \$3 million for the evaluation contractor. If the demonstration sites have typical per capita costs, this would mean that approximately 450,000 persons annually currently not receiving services would receive them through the demonstrations.

Estimate

Table D-2

**ESTIMATE OF THE COST OF
MEDICAID OUTREACH DEMONSTRATIONS:
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Outreach Activities				
	25	50	50	125
Services for New Eligibles				
	175	350	350	875
Evaluation Contractor				
	3	3	3	9
TOTAL	203	403	403	1009

3. Increasing Medicaid Coverage of Uninsured Populations

The Problem

The Medicaid program does not cover significant portions of the uninsured, such as single persons between the ages of 21 and 65. These uninsured populations are placing intolerable strains on the health care systems of a number of states. Given serious budget constraints and problems, many States would like to reduce what they consider to be non-essential services to some Medicaid groups and reinvest these resources into covering what they believe are essential services for populations currently ineligible for the Medicaid program.

Demonstrations To Increase Medicaid Coverage of Uninsured Populations

The Council recommends that legislation be developed that will permit two statewide demonstrations that decrease non-essential services to non-institutionalized Medicaid beneficiaries for the purpose of reinvesting these resources, together with federal matching dollars, in covering persons previously uninsured.

The major hypotheses to be tested will be:

1. States can and will cover more of the uninsured by reducing services to currently covered populations given the opportunity, and
2. States will increase overall State expenditures for health care if allowed to cover more of the uninsured by reducing services to currently covered populations.
3. The quality and adequacy of services to all population will not deteriorate

The legislation would allow the Secretary of Health and Human Services(HHS) to waive all necessary statutes and regulations to conduct such demonstrations. States would be required to apply to the Secretary for approval and agree to:

- Participate in an independent evaluation of the demonstration conducted by a contractor selected by the Secretary,
- Guarantees to be specified by the Secretary regarding the quality of care provided to those persons who experience a decrease in services, and
- Accept outlay limitations negotiated as part of the application process. Above these limitations, States would be liable for outlays.

The Secretary would be responsible for monitoring the demonstrations and reporting regularly on their progress.

Increased Federal Match for New Eligibles

Newly eligible persons would be matched at a rate of 75 percent federal funds. State administrative costs of the demonstration would be matched at regular administrative match rates.

Evaluation

The Secretary shall select an independent contractor to monitor and evaluate the demonstrations. As part of the contractor's final report, the contractor will pay close attention to the effects of the demonstration on those who receive decreased services.

Demonstration Costs

The Secretary shall award up to \$200 million per year for the two demonstrations, and an additional \$3 million for the evaluation contractor. If the demonstration sites have typical per capita costs, this would mean that approximately 200,000 persons currently not receiving services would receive them through the demonstrations.

Estimate

Table D-3

**ESTIMATE OF THE COST OF
INCREASING COVERAGE OF UNINSURED POPULATIONS:
Numbers in Millions of Dollars by Fiscal Year**

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Total</u>
Demonstrations	100	200	200	500
Evaluation Contractor	3	3	3	9
Total	103	203	203	509

Appendix E:

Summaries of Reports

THE SOCIAL SECURITY TECHNICAL PANEL REPORT

In December 1989 the quadrennial Advisory Council on Social Security convened a Panel of Technical Experts to review the assumptions and methodology used to project the future financial status of the old-age, survivors, and disability insurance (OASDI) programs. The Panel also was asked to review measures of the financial soundness of the OASDI system.

The Panel was chaired by Stephen G. Kellison, an actuary who serves as Chairman of the Department of Risk Management and Insurance at Georgia State University. The three other actuaries on the Panel were Donald S. Grubbs, Jr., President of Grubbs and Company; Sam Gutterman, Director and Consulting Actuary for Price Waterhouse; and Warren Luckner, Research Actuary for the Society of Actuaries.

Five economists also served on the Panel. They were Peter Diamond, Professor of Economics at the Massachusetts Institute of Technology; Michael D. Hurd, Professor of Economics at the State University of New York and a Research Associate at the National Bureau of Economic Research; Alicia H. Munnell, Senior Vice President and Director of Research at the Federal Reserve Bank of Boston; Lawrence H. Summers, Professor of Political Economy at Harvard University; and Finis Welch, Chairman of the Unicon Research Corporation and Professor of Economics at the University of California.

The Panel met monthly for 6 months, drawing on its own expertise and that of other economists and actuaries, as well as demographers.

The staffs of the Offices of the Actuary and of Research and Statistics at the Social Security Administration provided support for the Panel.

Generally, the Panel found the Agency's projection work to be professional and highly competent. The Panel made numerous recommendations relating to measures and tests of trust fund soundness, actuarial assumptions, and projection methodology. Its most important conclusions include the following:

- That a contingency reserve equal to at least 100 percent of annual expenditures be built and maintained throughout the 75-year projection period.
- That the Board of Trustees of the OASI and DI trust funds adopt tests of the soundness of the funds for both the short- and long-range. Failure of the system to meet these tests would alert policymakers and the public to the need for action to improve the financial status of the system.
- That three of the most critical economic assumptions used in making financial forecasts be changed; namely, that the assumed ultimate real interest rate be increased, the assumed ultimate real wage differential be decreased, and the assumed ultimate rate of inflation be increased.
- That the projection methodology appears reasonable; it has no discernible pattern of bias.
- That the projection methodology be externally reviewed and validated.

With regard to the most important demographic assumptions—the best estimate projections of mortality and fertility—the Panel made no suggestions for change.

The net effect of the Panel's recommendations relating to the contingency reserve and the economic assumptions is to change the long-range (75-year) summarized actuarial balance of the OASDI system from 0.91 percent of taxable payroll to 0.70 percent of taxable payroll under best estimate (II-B) assumptions.

In addition, the Panel made numerous other recommendations, including an agenda for further analysis and study. These research recommendations are summarized in Appendix A of the Panel's report to the Advisory Council. Its specific recommendations directly related to the Panel's mandate follow.

Summary of Recommendations

Evaluation of trust fund soundness and presentation of results:

Seventy-five years is an appropriate period over which to evaluate the soundness of the system.

A contingency reserve equal to at least 100 percent of annual expenditures should be built and maintained throughout the 75-year projection period.

A summary measure of actuarial balance should continue to be used and should:

- Continue to be based on the present-value method of summarizing income and cost rates; and
- Be modified to include the cost of building and maintaining a contingency reserve equal to 100 percent of annual expenditures throughout the projection period.

The Panel recommends that the Trustees Report highlight four additional measures of the system's financial well-being:

- The year in which the trust funds are projected to exhaust their reserves, as well as the first year in which the reserves fall below a fund ratio of 50 percent.
- The amount of any tax or benefit changes needed to bring the system back into long-range actuarial balance.
- The amount of transfers to and from Federal general revenues needed as special Treasury obligations are purchased and redeemed.
- The size of any difference between the cost rate and the income rate in the 75th year of the projection period, which is a measure of ultimate balance in the system.

A short-range test of the soundness of the OASDI system is necessary. The Panel recommends a test that applies to the first 10 years of the projection period and indicates whether the system:

- Has a contingency reserve or fund ratio at the beginning of each year of more than 50 percent, or
- Is projected to achieve a fund ratio of more than 50 percent within 5 years and remain at or above that level, and
- Has revenues sufficient to pay benefits in each month at the beginning of that month.

A long-range test of trust fund solvency is also needed. It should cover the 75-year projection period and should:

- Summarize actuarial balances for all valuation periods up to 75 years including both the beginning trust fund balance and the cost of building and maintaining a contingency reserve equal to 100 percent of annual expenditures throughout the 75-year period.
- Apply a tolerance level for an actuarial deficit of 5 percent of the summarized cost rate over the full 75-year period and grading uniformly to zero at the beginning of the first projection period.
- Use a present-value calculation.

The projection set now labeled "alternative II-A" and based on Federal budget assumptions should be eliminated and the remaining three sets should be labeled "low-cost," "best estimate," and "high-cost."

Assumptions

The Panel recommends that the ultimate best estimate (II-B) real wage growth assumption be decreased from 1.3 to 1.0 percent and that the low- and high-cost projection assumptions be set at 0.4 and 1.6 percent, respectively.

The Panel recommends an increase in the ultimate best estimate (II-B) inflation rate from 4.0 to 5.0 percent and increases in the low- and high-cost assumptions to 3.0 and 7.0 percent, respectively.

The Panel recommends an increase in the ultimate best estimate (II-B) real interest rate assumption from 2.0 to 2.8 percent and an increase in the low-cost rate from 3.0 to 3.3 percent. The Panel recommends no change in the high-cost assumption of 1.5 percent.

The Panel makes no suggestions for changing the level of the mortality assumptions. It does, however, suggest an assumption of continued increase for several years beyond 1990 in deaths from the Acquired Immune Deficiency Syndrome (AIDS) in the low-cost projections.

The Panel recognizes the uncertainty of future fertility trends. A majority of the Panel considers the ultimate total fertility rate of 1.9 as appropriate for the best estimate assumption, but would also consider

1.8 reasonable. The Panel recommends that the ultimate fertility rate for the high-cost projection be reduced from 1.6 to 1.4 in light of the current experience of certain developed countries.

The Panel recommends a net increase of 150,000 in the number of immigrants assumed in the low-cost projections.

The Panel suggests that consideration be given to using separate first marriage and remarriage rates.

The Panel makes no recommendation for changing the present retirement rate assumptions.

The Panel makes no recommendation for changing the present disability assumptions.

Projection Methodology:

The Panel recommends that additional resources be allocated to an in-depth analysis of the projection methodology.

Other Policy Issues:

Because of the complexity inherent in the OASDI system of taxes and benefits, changes in that system generally should be considered primarily on their own merit, rather than in the context of short-range budget debates.

The current investment policy for the OASI and DI trust funds seems reasonable.

The current statutory basis for an actuarial opinion should be continued and the statement of opinion should remain in the Trustees Report.

The automatic stabilizer in current law is of limited effectiveness. The role of stabilizers should be further analyzed.

A group with appropriate expertise should be convened to review technical and communications issues related to the Social Security Administration's (SSA) Personal Earnings and Benefit Estimate Statements.

SSA should explore ways to communicate financial information about the system to the general public in a more understandable way.

A new technical panel should be convened within the next 4 to 8 years.

THE REPORT ON MEDICARE PROJECTIONS BY HEALTH TECHNICAL PANEL

The Panel's findings and recommendations throughout the six chapters of the report follow.

Introduction

The Panel recommends that a new technical panel be convened in the next 4 to 8 years to review the Medicare program at that time.

Medicare Projections

The Panel recommends that HI revenues and costs continue to be projected over a 75-year period.

The Panel recommends that the current information in the SMI Trustees Report be supplemented with projections of the expected costs of the SMI program over a full 75-year projection period.

The Panel recommends that certain long-range projections of HI and SMI be made on a compatible basis so that the combined long-range obligations of the Medicare program can be clearly portrayed.

The Panel finds that the methods used to construct incurred experience are reasonable given the limitations of available data.

The Panel concludes that:

- The projection work by the Office of the Actuary (OAct) is highly competent;
- Given the limitations of available data, no better models are evident;
- Better data are needed to measure past experience as a basis for projecting future costs; and
- Because of data limitations, the projections for SMI are less sophisticated than those for HI.

The Panel recommends that more resources be devoted to enhancing projections for the SMI portion of the Medicare program.

The Panel recommends that more work be done to compare past Medicare cost projections with actual experience.

The Panel recommends strong Federal support for conducting research to develop long-term projections on the use and cost of health care services.

Assumptions Used for Medicare Projections

Assumptions Common to OASDI and HI. The Panel supports the recommendation of the Social Security panel to drop the II-A

projections for HI as well as for OASDI and to rename the remaining projections "low-cost" (I), "best estimate" (II), and "high-cost" (III).

The Health Technical Panel defers to the finding of the Social Security Technical Panel that the Trustees' intermediate, or best estimate, demographic assumptions are reasonable.

The Health Technical Panel defers to the recommendations of the Social Security Technical Panel to change the ultimate long-term economic assumptions for the intermediate, or best estimate, projections by raising the real interest rate to 2.8 percent and raising the inflation assumption to 5 percent.

The Panel recommends that the Trustees' ultimate best estimate real wage growth assumption be lowered from 1.3 to 0.7 percent.

Medicare Utilization and Payment Assumptions. The Panel concludes that the assumptions used to project HI and SMI costs for the next 25 years are based on reasonable extrapolations of past trends, enhanced by informed judgment about the potential effects of recent legislative and regulatory changes. The Panel concludes that both the assumptions and the resulting projections are reasonable.

The Panel recommends that long-range assumptions about the growth in HI and SMI payments after the first 25 years be monitored closely to ensure that the projections conform to trends developing under the prospective payment system (PPS) and the new resource based relative value scale (RBRVS).

The Panel recommends that the next Health Technical Panel include in its review the alternative I and III assumptions used to project the status of Medicare.

Contingency Reserves

The Panel recommends that the HI Trust Fund maintain a contingency reserve at a minimum level of 100 percent of the following year's expenditures.

The Panel also recommends that the cost of building and maintaining HI reserves at 100 percent of annual expenditures be included in the projected long-range cost and balance of HI.

The Panel recommends that SMI Trust Fund reserves (assets on hand minus liabilities for incurred but unpaid cost) should be allowed to range as high as 25 percent of the following year's projected incurred costs over an amount sufficient to cover deviations between projected and actual experience in the year.

Measures of the Financial Status of Medicare

Hospital Insurance. The Panel recommends a test of the short-run soundness of HI that requires a 100 percent trust fund ratio throughout the first 10 years of the projection period.

The Panel believes that a test of long-range balance similar to that recommended for OASDI could usefully be applied to HI, particularly

at a time when the HI system is closer to being in balance than it is now.

The Panel concludes that both the present value method and the HI method of calculating the HI actuarial balance have value and should be reported. It further concludes that the controversy over the methods used to calculate the actuarial balance has deflected attention away from the far more important issue; namely, how to deal with the huge long-range financial deficit in HI.

The Panel recommends that the Trustees Report clearly portray the magnitude of the imbalance in the HI Program over the 75-year period by showing the projected deficit as a percentage of the projected cost.

The Panel believes that the following measures should be highlighted for HI.

1. The year in which the trust funds are projected to exhaust their reserves, as well as the first year in which the reserves fall below a fund ratio of 100 percent.
2. The size of any difference between the cost rate and the income rate in the 75th year of the projection period, which is a measure of the ultimate imbalance in the system.
3. The amount of any tax or benefit changes needed to balance income and outgo over the long-range period.

Supplementary Medical Insurance. The Panel recommends that the following specific measures of SMI costs be portrayed over the long-term period.

1. Total SMI costs as a percentage of gross national product (GNP) and as a percentage of HI taxable payroll.
2. SMI premiums as a share of the average OASDI benefit paid to the elderly.
3. SMI costs net of estimated premium income as a share of GNP and as a share of HI taxable payroll.

Measures for HI and SMI Combined. The Panel recommends that:

- the HI Trustees Report include projections of the combined costs of HI and SMI over the 75-year projection period; and
- the OASDI Trustees Report supplement projections of OASDI and HI as a percentage of GNP with projections of OASDI, HI, and SMI as a share of GNP over the 75-year period.

Alternative Solutions

The Panel recommends that policy makers consider options for improving the financial status of Medicare not solely in terms of annual budget policy, but rather in terms of structuring the best possible health program for the aged and the disabled given the amount of resources society is willing to allocate to it.

INCOME SECURITY AND HEALTH CARE: ECONOMIC IMPLICATIONS 1991–2020 AN EXPERT PANEL REPORT TO THE ADVISORY COUNCIL ON SOCIAL SECURITY

The year 2020, which seems far into the future, is actually closer to today than is the year 1960. Thus most readers can visualize the year 2020, at least in a demographic context, by projecting nearly 30 years into the future. Those of us who represent the "first wave of the baby boom" will be in our seventies, most likely retired, receiving our Social Security checks, and using our Medicare benefits. Our children will be well settled into their career paths, contributing to Medicare and Social Security, paying for private insurance for their families, and saving for their retirement. Our grandchildren will be in school or possibly just starting their careers.

The charge to the Expert Panel, appointed by the 1991 Advisory Council on Social Security, was to provide a broad review of the economic and social policy issues that must be addressed in considering the combined financing of the health, income security and long-term care needs of an aging population. Thus, the task before the Expert Panel on the Future of Income Security and Health Care Financing was to project the health care financing and income security environment of today forward to 2020 and to assess what implications the projections have for the policy-makers of today.

The Panel limited its analysis in two important ways: (1) The Panel assumed no significant changes in current policy and (2) The Panel built its analysis largely from existing data projections, recognizing there is insufficient time and resources to do its own projections. The Panel acknowledges inherent limitations in making long-range projections, since changes in assumptions and policy actions could alter the outcome. Additionally, advances in science and technology could alter outcomes in dramatic and unpredictable ways. Nevertheless, the Panel felt that the exercises would be instructive and relevant. Unless some assessment of the future is made, there is no basis for taking action today that could beneficially affect the future.

The projections indicate that the world of 2020 will be characterized by an aging society. When compared with children and working age adults, the elderly are—and will be—the fastest growing population segment. In 2020, the elderly who are age 65 and older will represent more than 16 percent of the population, compared with 12 percent today. The elderly who are age 85 and older are projected to increase the fastest, nearly doubling between now and 2020. The number of workers to support each beneficiary of the Social Security program for the elderly (and others, such as the disabled) will decline from 3.4 per beneficiary in 1990 to 2.4 in 2020. In general, the elderly in 2020 will have higher real incomes than today's elderly, although women living alone and the elderly over 85 will still have low levels of income. Consumption of other goods and services and assets of the elderly will be reduced by higher expenditures for medical care.

Most significantly, the projections show the striking consequences if health care expenditures continue to grow at their historical rate. Projections were calculated based on four different assumptions of

growth rates. One of the projections assumes a very modest reduction in the rate of growth in real per capita health spending from what we have recently experienced and still shows health care consuming 31.5 percent of GNP in 2020 compared with the 1990 level of 12.2 percent. Another projection assumes a greater reduction in the historical rate of growth and shows health care reaching 22.7 percent of GNP in 2020. These two projections, used to illustrate a range of possible implications, are the basis for much of the comparative analysis in the report.

The Panel considered these trends, the estimates of resources available to the Nation and to the individual in 2020 and the resulting implications for our future economy.

Impact on the Nation's Economy in 2020

A major part of the Panel's analysis was a macroeconomic view of the economy in 2020 focusing on the allocation of gross national product. The Panel's assumptions about the level of GNP in 2020 were based on the intermediate economic and demographic assumptions from the 1991 Trustees Reports on Old Age and Survivors Disability Insurance (OASDI), Hospital Insurance (HI), and Supplementary Medical Insurance (SMI). The Panel developed an analytical exercise in which two different economic scenarios of 2020 were constructed. The scenarios differ only with respect to the two different projections of health care expenditures in 2020 identified above.

As a result of this exercise, the Panel made the following observations for 2020:

- Between now and 2020, the aging of the population has only a modest effect on the Nation's economic patterns.
 - The demographic change should have only a moderate effect on the pattern of nonmedical consumption to which our flexible market economy should be able to adjust.
 - Many elderly sell financial assets after retirement because they consume more than their incomes. Therefore, the aging of the population is expected to reduce the national savings rate, but the effect appears to be moderate. Although some elderly sell their houses, any increase in sales is unlikely to reduce housing prices substantially because the changes will happen slowly enough to allow the housing sector to adjust.
 - More resources will be required to support the public and private retirement systems (i.e., Social Security and employer-sponsored retirement plans), but the new levels should not, by themselves, cause an excessive burden.
- With the inclusion of health care expenditure growth, however, the analysis indicates that the Nation cannot continue its pattern of consumption growth and at the same time devote an ever-increasing share of GNP to health care services. The resource requirements for health care leave less available for the other needs of the Nation.

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- The decumulation by the foreign sector of current financial assets of the United States and possible reduction of direct investments in the United States by the foreign sector because of aging demographics of other developed nations will likely result in even greater need for capital than that reflected in the alternative scenarios.
 - It is unlikely that the United States will experience a growth in the economy that exceeds the projected increase in health care expenditures. Based on the exercise conducted by the Panel, the economy would have to grow about three times as fast as the growth projected by the Trustees. Consequently, unless the growth in health care expenditures is significantly reduced, we cannot expect to "grow out" of the effect of rising health care expenditures. Rather, it seems more likely that the United States may further decrease savings and other consumption items.
 - Although there was not a detailed study of the economy after 2020, it was noted that the effects of an aging population should accelerate between 2020 and 2030 because of the complete retirement of the baby-boom cohort. This effect and the cost of long-term care services will have additional significant implications between 2020 and 2040.

Health Care Projections to 2020

Four health care projections, developed by the Health Care Financing Administration,¹ were available to the Panel. Over the past 20 years real per capita health care expenditures grew by 4.4 percent per year, on average. During the last 10 years they grew at an average annual rate of 4.7 percent. The comparable average rates of growth over the next 30 years under the four projections are summarized in the following table:

<u>Projection</u>	<u>Percent of GNP in 2020</u>	<u>Rate of Real² Per Capita Growth Assumptions</u>
1	36.0 percent	4.7 percent—a continuation of existing trends over the past decade
2	31.5 percent	4.3 percent—slower than the past decade but consistent with longer-term trends
3	22.7 percent	3.1 percent—significant slowing of existing trends
4	13.7 percent	1.4 percent—immediate and drastic curtailment of health expenditures

¹Office of the Actuary, HCFA

²In constant dollars using the GNP implicit price deflator

The Panel recognizes that these projections are not true predictions of health care consumption. Health care consumption may be very different, as health care expenditures become influenced by future policy decisions and other unknown factors. However, in the absence of major policy changes, the Panel believes that the Projections 1, 2, and 3 are plausible. The Panel believes that Projection 4—which assumes immediate and drastic curtailment in the rate of growth and is reviewed primarily for illustrative purposes—is implausible.

The Panel found it noteworthy that the aging of the population contributes only modestly to the escalating health care expenditures. Changes in the age and sex distribution of the population from 1990 to 2020 account for a relatively small part of the projected growth in medical care expenditures as a percent of GNP. The age distribution will have an impact on the allocation of health care expenditures between private and public programs, because of the increased costs of Medicare resulting from the retirement of the baby boom.

Growing intensity in each service delivered has been a significant contributor to cost escalation over the last 20 years. The effects of population aging alone are less than popularly believed. Over the past 10 years, medical inflation, intensity, and utilization have been the most significant contributors to cost escalation. Intensity and utilization—as distinguished from inflation and population growth—have the greatest potential for being influenced by changes in health policy.

Effect on Individuals in 2020

The Expert Panel examined demographic, income and health care projections to assess what 2020 could be like from an individual's perspective, considering Projections 2 and 3 of health care expenditures.

Income for workers and the elderly will continue to increase over the next 30 years.

- On average, income for the elderly will increase slightly faster than for the average worker. The income of those over 85 and unmarried women will grow less rapidly than that of the younger elderly.
- Increases in income for the elderly are largely attributable to projected increases in the payment of private pensions. The Panel recognizes that many uncertainties are associated with projecting the future of pension systems.
- In recent decades, growing inequalities in the earnings distribution of men and of women portend growing inequalities in total household incomes.

The expected income gains of workers may be offset by increased expenditures for health care and support for social programs for the elderly.

- The cost of Social Security and both parts of Medicare (HI and SMI) combined, expressed as a percent of taxable payroll is

projected to approximately double over the next 30 years from approximately 15 percent to approximately 32 percent (under health spending Projection 2) or to 26 percent (under health spending Projection 3).

- Part A (HI) of Medicare³ is funded largely by payroll tax. The 1990 rate of combined employee/employer contributions is 2.9 percent. The cost of HI is projected to rise to between 6.4 (Projection 3) and 8.9 percent (Projection 2) in 2020.
- Part B (SMI) of Medicare is financed through premiums and general revenues, not by a payroll tax; however, expressing the revenue required as a percentage of payroll is useful. The effect of this calculation shows Part B rising from an equivalent of 1.79 percent of payroll in 1990 to between 6.2 (Projection 3) and 8.7 percent (Projections 2) of payroll in 2020.
- The cost of Social Security is influenced largely by the growing number of beneficiaries relative to workers. In 2020, the cost of Social Security will exceed projected annual revenue from payroll taxes by about 1 percent of taxable payroll.

³The 1991 Trustees Report indicates Medicare Trust Funds for Part A will be depleted by 2005. The calculation of the contribution rate assumes Part A will continue in its present form and will be adequately funded by setting tax rates equal to expenditures in the future.

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- In addition to increased payroll taxes, the adult working age population can expect increases in out-of-pocket costs for health care and health insurance premiums.
 - Private insurers are expected to more than triple their per capita payout, in real terms, under Projection 2, or double under Projection 3.
 - Such increases may indicate significant growth in the share of employee compensation allocated to health insurance—either as fringe benefits financed by employers or as employee contribution from wages.

The income gains of the elderly are also expected to be offset by expenditures related to medical care. Medicare only covers approximately 45 percent of the elderly's total health care costs, including long-term care.

- The rise in Medicare costs could mean the elderly will experience a rise in the premium for Part B. If the Part B premium continued to fund 25 percent of the Part B program, in 2020 the premium would roughly triple as a share of the median income of the elderly (under Projection 2) or more than double (under Projection 3).
- Out-of-pocket health care expenditures are much larger for the elderly today than for the nonelderly and are expected to continue to increase in the future.

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- Nearly half of all nursing home care expense is paid for directly out of pocket. Estimates indicate actual per capita out-of-pocket costs could double by 2020. Approximately two of every five persons surviving to the age of 65 are estimated to experience a stay in a nursing home.

The number of uninsured could be significantly influenced by future policy changes. A person's willingness and ability to obtain health insurance is related to the person's level of real wages and income, relative to the price of private health insurance and the availability of uncompensated care for persons uninsured. Under assumptions used in this report, real wages are assumed to grow by 1.1 percent, while real per capita health care spending is projected to rise by 4.3 and 3.2 percent, respectively, under Projections 2 and 3. The panel anticipates that the difference in real wage and the price of insurance, especially if providers continue to provide uncompensated care under the same terms as at present, may well lead to an increase in the number of uninsured. This trend will be slowed, however, by the change in the age distribution, which will lead to a larger fraction of the population having coverage under Medicare.

Risk and Uncertainties in 2020

The Panel considered what risks and uncertainties might face the elderly of 2020 with respect to the public and private institutions now available to today's elderly.

The Panel concluded that the realization of the benefits expected from Social Security and employer-sponsored pensions, which are a major

factor in the financial well-being of the elderly in 2020, is highly likely, although certain risks and uncertainties must be addressed, especially with respect to the design and funding security of employer-sponsored as well as public employer pensions.

The rising costs of health care make the financing of Medicare and employer-sponsored retiree health care benefits problematic. If Medicare or employer-financed coverage is reduced, the elderly would need to increase the proportion of their income spent on health care. This could pose a threat to the economic security and well-being of the elderly, particularly to certain vulnerable groups such as the old elderly and women living alone who have dwindling assets and rising health care costs.

Summary of Analysis

The following major observations emerge from the look at 2020 by the Expert Panel:

- From both the perspective of society and the individual, the benefits from future gains in income and wealth are significantly reduced by the growing resources required to support the health care sector.
- The aging of the population, with its implications for the special needs of the elderly, and the increasing burden on the working-age population to support social programs for the elderly cannot be ignored. Our society will accommodate the necessary adjustments if health care costs are maintained at a reasonable level.

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- The growth of the costs of medical care projected through 2020 is attributable to a continued increase in the intensity of care and medical inflation. The contribution due to the aging of the population is modest. However, demographic changes, especially growth among the very old, may result in nursing home use nearly doubling. Although long-term care is less technologically intense than acute care, intensity for long-term care is also projected to increase.
 - The Expert Panel believes it is critical to focus attention on the potential deleterious effects on the entire economy if the cost of health care continues to rise unabated. The potential adverse effect requires intentional policy intervention in the very near term. The Expert Panel believes it is not tenable for health care to continue to grow along the existing trend line. Even moderate growth in health care will place great demands on society's resources.
 - Many expect that the rising cost of health care, combined with issues pertaining to the number of people facing barriers to needed care in today's health care system, will continuously generate pressure and tension within the political system and that some measure of policy reform will be undertaken in the near term.

Conclusions and Lessons for Today

The Panel's analysis of 2020 underscores the importance of long-range analysis of social policy issues. The Panel believes that the potential command of future resources makes this critical for health care. Most analyses for new policy options cover only a short horizon projection.

Even though there are limitations associated with long-range projections, they provide valuable insight into potential problem areas, the possible magnitude of change that can be expected, the areas of relative growth, and the potential impact on other economic sectors.

Health care reform must be considered in a broad social policy context. Financing policies for both public and private health care must consider the effect of future demographics, income and wealth distributions, and their anticipated impact on economic growth. GNP, by itself, is an insufficient measure of affordability of health care. Other factors that measure the financial burden of health care and social programs on the individual and business must be considered. Developing a systematic approach to measuring the effect of major policy reform and identifying barriers to consensus is a valuable, albeit difficult, pursuit. Tools that further this objective are encouraged. Suggested criteria to assess approaches to reform and a research agenda are included in the report.

The Nation faces serious health care financing problems, particularly in the next century. The issues facing policy makers are not easy to resolve. Reform requires a balance of fairness that can be maintained into the future. The Panel recommends that major policy decisions about the design and financing of health care should be developed not solely in annual budget negotiations, but rather from a long-term perspective that aims to design the best possible health reform program, given the resources that Americans are willing to devote to that purpose.

Further, the Panel concluded that the projected increase in health care expenditures through 2020 is dramatic under all plausible scenarios.

The major factor in the rise in acute care costs is not demography. Instead, increases come from the ongoing evolution in technology, in the way that we use health services, and in the structure of our health care delivery and financing system. Since ongoing trends in these systems will exacerbate future problems, it is important to start significant change in our system as quickly as possible by a health policy that can appropriately contain these cost trends.

The issue of access to health care is of comparable importance to the issues of cost level and cost increases. There are no available projections of the number of uninsured to the year 2020. Having considered the trends of medical costs relative to wages, the size and aging of the population, and developments in the insurance market, the Panel concluded that it is very likely that a projection of the number of uninsured in 2020 would show more uninsured than there are at present. Since the projection gives no reason to expect improvement in access without major government intervention, the problem of access to medical services should be faced as quickly as possible.

Different methods of providing increased access lend themselves to different methods of cost containment; so it is best to consider these two issues simultaneously. Since there are a limited number of approaches to universal (or nearly universal) access, the natural first step in the analysis of health policy is to list currently discussed approaches and contrast their characteristics and impacts. The natural second step would be to compile a list of the many different government actions that can be taken to limit cost increases. Because different cost-containment mechanisms fit with different methods of providing universal access, the third step would be to combine the approaches toward universal access with approaches toward cost

containment, generating a matrix of combinations. There was strong interest by the Panel in further development of this approach; however, time did not permit further analysis.

The Nation faces the dual challenge of expanding health care coverage to those who are now inadequately insured and of containing the costs of that care. The Panel's projections indicate that, in the absence of action today, health care will absorb an alarming proportion of the country's resources by the year 2020 and that the number of Americans who are inadequately insured will increase. The Panel wishes to reiterate its sense of urgency about these issues and concludes we must address these challenges now.

A MESSAGE FROM THE AMERICAN PUBLIC: A HEARINGS AND SITE VISITS REPORT OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

In accordance with Section 706 of the Social Security Act, in 1989, Secretary of Health and Human Services, Louis W. Sullivan, M.D., appointed the Advisory Council on Social Security. Among Secretary Sullivan's charges to the Council were examination of: the broad policy issues in Social Security, such as its role in overall U.S. retirement income policy; the Nation's health care financing to include Medicare and Medicaid; and health care delivery systems.

Recognizing the vitally important role that the American people must play in any debate concerning our Nation's health care and Social Security systems, the Council, between the Summer of 1990 and the Spring of 1991, convened 10 public hearings in key cities throughout the country.

The hearings provided an opportunity for testimony from both scheduled witnesses and members of the public, including state and local officials, health care professionals and administrators, representatives of non-profit organizations, consumers, insurers, scholars, business leaders, and advocates for the poor, the elderly, and women. These individuals provided the Council with valuable insights on health care financing and delivery issues, better access to health care, the role of Social Security in retirement planning, the adequacy of Social Security benefits for widows and widowers, and other aspects of the United States' social insurance system. As part of this

process, the Council also conducted 73 site visits in over 25 cities and towns to various health and elder-care facilities, Social Security offices, and teleservice centers across the country.

This report is a summary of testimony presented at the hearings and information drawn from the site visits.

Social Security-Related Issues

Social Security, the largest income maintenance program in the United States, was designed as a supplement to other sources of retirement income.

Social Security is an earned right, with eligibility based on a tax on workers' pay. It is the single largest source of income for elderly families in the United States; 38 percent of elderly families currently rely on Social Security for at least 80 percent of their income.

At the Council's hearings, the majority of witnesses underscored their belief that Social Security should remain an important part of the retirement income system in the United States. Although the Council heard complaints about certain aspects of the Social Security program, it was clear that the majority of Americans are pleased with the program.

The Council also found many misconceptions about the Social Security program. For example, few people expressed an understanding of the social insurance aspects of the program. In addition, few seemed to understand the relationship between

contributions and benefits, the principle of near universal-coverage, or the compulsory nature of the program.

Some witnesses voiced reservations about the level of Social Security benefits. Others argued for a drastic restructuring of the system, specifically urging a means-tested eligibility. Noting the relatively high return on IRAs or other private savings vehicles, a few argued in favor of government-mandated IRAs as a substitute for Social Security.

Witnesses also testified on the retirement earnings test, which is used to measure outside income to determine if benefits should be limited. Most of the people who testified on this subject believed the test should be eliminated. They argued that wealthier Social Security beneficiaries could supplement their benefits with investment income, while poorer beneficiaries without investments were penalized when they supplemented their benefits by working.

The Council also heard a great deal of testimony on women's issues. Although the Social Security program is gender neutral, periodic reexamination of the program has raised three historic areas of concern: the effect on benefits of the time a woman spends out of the work force in caregiving activities; the potential benefit inequities for working wives and two-earner couples; and the adequacy of benefits for widows and widowers, the poorest groups receiving Social Security benefits. The vast majority of witnesses believed that benefits for women are too low. Several testified that displaced homemakers, married for most of their lives and then divorced, were hardest hit since years without earnings adversely affect Social Security benefits.

The disability determination process was another topic of testimony. Most of the witnesses were dissatisfied with the process. Complaints ranged from a lack of uniformity in determinations to the length of time for decisions. Other problems cited were lack of appropriate compensation for in-house medical consultants and consultative examination providers, which witnesses said has a negative impact on both processing time and quality.

The Social Security Administration's service to the public was also a topic at several hearings. Many testified that services and client satisfaction remain high. They discussed the results of a survey conducted in fall 1989 by the Office of Inspector General for the Department of Health and Human Services, which showed that most clients continue to give Social Security service a high rating. This finding occurred at a time when the Social Security Administration had completed staff reductions, had implemented a national toll-free 800 telephone number, and initiated automated claims processing. On the other hand, Union and Legal Aid representatives said they believed there has been a significant decline in services as a result of budget cuts and staffing reductions. These witnesses focused on Social Security's toll-free 800 telephone number, a lack of personalized attention, and the quality of notices.

Public Health Care Financing

Upon creation of the Medicare and Medicaid programs, the Federal government became a major payer for health services in the U.S. Medicare is the national health insurance program for the elderly, the disabled, and persons with end stage renal disease. Medicaid is a

program funded by both Federal and State governments to provide coverage for acute and long-term care health services for certain categories of poor individuals.

Based on testimony the Council heard, the public generally favors the Medicare program, but does have certain concerns about coverage and reimbursement. In particular, witnesses noted that Medicare does not cover eye and hearing exams, preventive care services, and prescription drugs. Concerns were also expressed about the difficulties many beneficiaries face in meeting the required copayments, coinsurance, deductibles, and premiums. Several witnesses advocated relating the Medicare premiums and cost-sharing to income, so that elderly persons with higher incomes would pay greater premiums, copayments, coinsurance, and deductibles.

A great deal of testimony and site visit discussion centered on Medicare reimbursement rates. Many providers cited financial difficulties encountered in treating the elderly, and this was a special concern with public and voluntary hospitals. For example, the Council heard testimony that in 1990, California hospitals lost \$800 million because Medicare reimbursements did not cover the actual costs of provider's care.

Providers, advocates, government officials, and consumers testified in support of the Medicaid program, but expressed concerns about the eligibility requirements and processing of eligibility determinations and claims. Several suggested that the eligibility rules for Medicaid be established nationally, rather than on a State-by-State basis. Some also suggested that eligibility for Medicaid be separated from eligibility for other income assistance programs in order to increase

the number of people who can qualify. Hospitals, physicians, and consumers testified that Medicaid rates paid are less than the cost of patient care.

Despite these problems, the Council heard that some States and providers are working to encourage enrollment in Medicaid. For example, Florida has shortened its eligibility application form to one page and has "outposted" more than 400 eligibility workers into health care facilities to help with the eligibility process.

Long-Term Care

The Council learned that many factors, including lifestyle changes and advancements in technology, are extending the American life span and ensuring that many younger victims of disease and accidents survive. These demographic changes place an increasing burden on caregivers, nursing homes, and other community-based settings.

Witnesses voiced concern over the lack of public awareness about the limits of Federal coverage for long-term care services, the costs of those services, the shortage of community-based long-term care, and the quality of institutional services. Witnesses testified that there is a bias toward institutionalization in long-term care, which results from the coverage of institutional care by Medicaid and private long-term care insurance. These witnesses urged that public policy encourage greater use of community-based services which offer greater independence, choice, and quality of life. Many witnesses testified that they believe that Medicaid reimbursement rates and staff wages adversely affect quality of care.

In addition, the Council heard several types of recommendations to address long-term care service and cost issues. Some witnesses recommended the integration of acute and long-term care services. Others testified in favor of increased funding and accelerated research on conditions such as incontinence and Alzheimer's disease that cause individuals to need long-term care services.

Acute Health Care Delivery System

The lack of private health insurance for some individuals and the complexity and low reimbursement rates of public programs can impede access to primary care for the uninsured, the elderly, and the poor. Certain segments of the health care delivery system, primarily public and voluntary hospitals and community health centers, serve as the first point of access to health care for these individuals. The Council heard many positive examples of the efforts that public hospitals and community health centers are making to care for these individuals.

The Council visited and heard testimony from representatives of several community clinics and federally-funded community health centers, who said that they face a major problem with recruitment and retention of personnel due to salary levels and practice locations, which are often rural, isolated, or in inner cities. Similar difficulties in recruiting and retaining personnel were expressed by inner-city public hospitals such as Cook County Hospital in Chicago and Harlem Hospital in New York City.

The Council also found that pregnant women who receive inadequate or no prenatal care present a major problem for the health care delivery system, and particularly place burdens on public and voluntary hospitals. This is especially true in border areas, where many pregnant women cross the border solely to give birth in the United States so that their children are American citizens, and in inner-city areas, where a higher percentage of babies are drug-exposed or HIV-infected. Inadequate prenatal care leads to low birth weight babies, for whom care is expensive.

Throughout the country, the Council heard positive testimony about the efforts States and localities are making to increase access to prenatal care. In Florida and Massachusetts, for example, hospitals are establishing centers to provide comprehensive prenatal care to pregnant women. In Chicago, workers provide education in public housing projects to teach mothers about prenatal and postpartum care, as well as parenting skills.

The Rising Costs of Health Care

Americans are spending more and more on health care. In 1990, the costs were \$666.2 billion or 12.2 percent of the gross national product. The Council heard testimony about many of the factors contributing to this trend, such as the aging of the population, the public's demand for high-technology care, the fear of malpractice lawsuits, the high cost of malpractice insurance, and the cost of administration, which have contributed to the rise in health care costs.

While most agreed that it is important to slow the growth of health care costs and institute cost-containment measures, various strategies and proposals to achieve these cost-containment goals were described. Two approaches discussed at length were managed care and selective contracting. Managed care refers to interventions by, or on behalf of, a payer to control the cost and volume of health services in order to maximize the value of benefits provided. Selective contracting is an innovative approach to streamline and contain the costs of care through contracts with health care providers to provide specific health care services.

Witnesses also suggested cost containment through malpractice reform, to include limits on non-economic damages as well as attorney's fees. They also favored placing limits on the use of technology that is unlikely to benefit patients, reducing administrative costs, and increased emphasis on disease prevention and individual responsibility for healthy lifestyles. Many conditions which normally require substantial medical interventions, such as heart disease and some forms of cancer, could be prevented if individuals did not engage in unhealthy behavior such as cigarette smoking and adopted healthier behaviors such as exercise and sound eating habits.

Health Care Insurance for Small Business

The costs of health care and health insurance can be barriers to care, leaving many millions uninsured and underinsured. The Council was told that more than half of the uninsured are employed persons and/or their dependents. The employed, uninsured persons often work for businesses with fewer than 25 employees that offer no health insurance. According to the National Federation of Independent

Business (NFIB), 65 percent of NFIB members provide health insurance for their employees. Two-thirds of those that do not provide health insurance would like to, but their wish is tempered by cost considerations. Employers that do provide health insurance coverage testified that high health care premiums, averaging between 20 to 25 percent every year, affect their decision to continue coverage.

Witnesses advocated several proposals for increasing access to care, including employer mandated health care benefits. The small business community, while agreeing that Americans should have access to health care services, said that the answer does not lie with employer mandates. Several witnesses argued that mandated benefits would increase unemployment, as more businesses are forced to close their doors. As one witness put it, ". . .with mandated health benefits, we put me out of business, and we put my 500 people out of work, and they become a problem—or at least the majority of them become a problem for government—because there is no employer then to provide health benefits." Many argued that, even if employer mandated proposals were combined with tax deductions, tax credits, or other incentives, the ability of the employer to provide health care insurance is hindered by the unpredictability of high premiums and uncertainty about future rises in health care costs. Witnesses also argued that state mandates add to the costs of health care insurance and preclude them from offering health insurance coverage.

Barriers to Access to Health Care

Access to health care is often considered synonymous with access to health care insurance. While lack of health insurance is often a barrier

to care, the Council learned that the barriers that can make the U.S. health care system difficult to negotiate include the lack of information and complexity of the insurance system; gaps in insurance coverage; language, education, and cultural differences and perceptions; lack of transportation; and the uneven distribution of health professionals.

The Council found some innovative ways in which these barriers are being overcome and access to health care is being improved at particular sites throughout the Nation. For example, the Council heard how the Department on Aging in Chicago has begun to publicize and to publish most of its materials in Polish, Chinese, Cambodian, and Korean in order to be responsive to the different ethnic groups that it serves.

Children and Adolescents

Of the 34 million Americans without health insurance, a large number are uninsured children. To improve coverage of this population, witnesses suggested increasing the scope of Medicaid coverage to include more or all children. They also urged that policymakers examine child health in the context of the family, environmental and economic influences, preventive health, mental health, and substance abuse, all of which have a tremendous impact on the health of America's children.

The Council was interested to learn that many States are finding positive results from school-based clinics which encourage preventive health care visits by children. Most of these clinics operate free of

charge to students and help eliminate the barriers of cost, transportation, and safety.

Cooperative Ventures

From coast to coast, the Council saw dynamic examples of cooperative ventures dedicated to solving the health care problems faced by the Nation. This process reinforced the Council's views about the effectiveness of local solutions designed to solve local problems. The Council heard testimony about a myriad of task forces, public officials, and interested individuals who are assessing community solutions to particular health care problems. Many initiatives are related to expanding access and ensuring continuity of care. In Florida, for example, the State developed the Health Care Access/Primary Care Program to provide a consistent source of medical care for the poor and medically indigent through a coordinated system of primary care programs funded by State tax revenues. Services are provided at no cost to eligible persons with incomes under 100 percent of the Federal Poverty Guidelines (FPG) and on a sliding fee schedule between 100 and 200 percent of the FPG.

Another example of community solutions to health care problems is collaborative efforts between various sectors. In New York City, for example, a major project is underway to bring together key city officials, child health leaders from the voluntary sector, and corporate leaders to collaborate in the development of policies and programs to improve the health of children. It has become increasingly clear that these collaborative efforts create not only common sense linkages, but provide workable, cost-effective solutions that meet divergent

community needs. But successful community-based efforts are not possible without a strong base of volunteers, even though it is evident that volunteers are only one part of the solution. In a climate of competition for financial resources from all levels of government, as well as the private sector, the Council was impressed by the persistence of volunteers in accomplishing their goals. In the final analysis, the health care problems that this Nation faces cannot be solved by any one sector alone, but by continuing to energize the existing cooperative spirits of both the public and the private sectors to work together for more creative solutions. Improving access to health care for Americans requires the ingenuity and energy of both public and private organizations.

A MESSAGE FROM THE AMERICAN PUBLIC: A REPORT OF A NATIONAL SURVEY ON HEALTH AND SOCIAL SECURITY BY THE ADVISORY PANEL ON SOCIAL SECURITY

Overview

The Advisory Council on Social Security in order to obtain first-hand information from American citizens on their knowledge, perceptions, attitudes and opinions about the Social Security program and the health care system in the United States conducted two national telephone surveys in October and November, 1991. These two surveys were designed to be comprehensive examinations of public views in health care and Social Security. Each survey interviewed more than 1,200 adult Americans. In both cases, national random-digit probability surveys were employed and extensive call-back procedures were used to ensure random, reliable samples.

The design phase for both surveys began with an extensive review of public domain data provided by the Roper Center for Public Opinion Research. Questions were reviewed by policy experts and a bi-partisan panel and the instruments were pre-tested extensively prior to the actual administration of the survey.

Past Surveys

Many national surveys conducted over the past few years have included questions relating to various aspects of the Social Security

program and the health care system in the United States. Regarding Social Security, questions have been asked about: (1) support or opposition to increasing Social Security taxes; (2) expectations about Social Security as a source of retirement income; (3) the relationship of Social Security to the budget deficit; (4) status of the Social Security trust fund; (5) perceptions about the financial status of the Social Security system; (6) the level of Social Security taxation; and (7) cost of living adjustments (COLAs) in benefits.

In 1979, Peter D. Hart Research Associates conducted 1,549 personal interviews on behalf of the National Commission on Social Security. Similarly, in October, 1991, the Advisory Council On Social Security conducted a comprehensive national survey examining knowledge, perceptions, and options facing the Social Security system. Several select questions in the 1991 Survey duplicate questions in the 1979 Hart survey so that the results could be compared with each other. In these cases, the Council found the results of the surveys to be similar.

In the area of health care, there has been a growing amount of inquiry since the mid-1980s. Much of this work was related to the catastrophic care debate. Other surveys have dealt with health issues in a piecemeal fashion by including health care questions along with other national issues, such as the economy and defense spending. Many of these surveys have attempted to: (1) gauge public support for or opposition to Canadian-style national health insurance; (2) the extent to which people feel reform is necessary; (3) satisfaction with health care and health insurance; and (4) the health care delivery system. Much of this work has attempted to measure these complex issues with a few broad questions. Such an approach fails to consider programmatic realities, including the effects of specific options on

consumers and providers, or is too simplistic to provide as accurate measures.

There has been some detailed research performed as well. Robert J. Blendon, Karen Donelan and others have performed extensive examinations of current research on the health care system in the United States and in other countries. This work has explored the concerns of both the public and opinion leaders by examining public support for health care reform, national health insurance, problems of escalating health care cost and access to the health care system, and willingness to pay for expanded health coverage.

In their article "The Public and the Emerging Debate over Nation Health Insurance" (*New England Journal Of Medicine*, July, 1990), Blendon and Donelan cited national surveys conducted by the *Los Angeles Times* and Gallup in 1990 that showed nearly three out of four Americans favor some form of a national health care program. In a later article, "National Health Insurance: Does the Public Buy It" (*The Public Perspective*, March/April 1991) they cited research conducted in April, 1990 and October, 1990 by CBS News and *The New York Times* that indicated public support for national health insurance was at a somewhat lower level (56 percent and 64 percent respectively).

Blendon, in the *New England Journal of Medicine*, indicates that Americans are unsure of how a national system should be financed. Further, the public tends to dislike systems that would limit the choice of a physician or involve waiting for service. Also, he writes that the American public is resistant to paying the increased taxes needed to finance a comprehensive national health insurance program.

Despite the extensive research efforts undertaken by Blendon and others, these surveys have, for the most part, provided an analysis that was limited to aggregate and cross-tabular breakdowns of public response, or lower-level statistical analysis, rather than extensive multivariate statistical analysis. Few, if any, have attempted to determine statistically the underlying factors driving perceptions and attitudes about the Social Security and health care systems, support or opposition to reform proposals, and the relationships among variables.

The analysis performed on The Council's surveys presented here goes far beyond the level of analysis provided in other surveys. Rather than collecting only nominal and ordinal-level data, many questions were designed to provide interval level data. As a result extensive multivariate analyses (including analysis of variance and multiple regressions) were performed to examine the relationships among variables and answer such questions as: what factors drive desire for change, willingness to pay additional taxes to provide coverage for the uninsured or to expand or continue program benefits, what is the intensity of support for health reform options, and many others. This analysis, then, goes far beyond demographics and, in fact, shows that demographics alone tell only part of the story and explain little about attitudes and perceptions of the health care system.

Comparison With Past Surveys

Most of the questions for the Advisory Council On Social Security were designed specifically for the health care survey. They provide new insight into Americans' views on health care. However, some questions were similar to items that have been included in previous national surveys. The results of these questions, conducted by a

variety of sources and obtained through the Roper Center for Public Opinion Research, are very similar. The Council obtained similar survey results.

The comparison of results indicates that attitudes and perceptions regarding the quality of health care, satisfaction with and confidence in personal health insurance coverage, perceptions about the adequacy of coverage in case of a major medical expense, and the extent of employer-provided health benefits have changed little during the past two years. The similarities are demonstrated as follows:

Quality of Health Care

The Advisory Council On Social Security survey found that 78 percent say they are satisfied with the quality of their health care services while 18 percent are dissatisfied. These results are almost identical to those in a CBS/*New York Times* survey conducted in August, 1991 in which 78 percent were satisfied and 19 percent were dissatisfied. Little change is evident since a January, 1990 Gallup survey showed 82 percent satisfied and 15 percent dissatisfied.

Satisfaction with Health Insurance

Council survey results show that 78 percent are satisfied and 21 percent are dissatisfied with health insurance. In January, 1989, results of a survey conducted by NBC News showed 78 percent were satisfied and 18 percent were dissatisfied.

Adequacy of Insurance

Sixty-five percent surveyed said they are confident that they have adequate insurance to meet major medical expenses while 33 percent are not. In a Gallup survey conducted in February, 1990, 66 percent said they were confident and 31 percent said they were not.

Employer Coverage

In a *New York Times* survey conducted in June, 1989, 61 percent reported that they or a family member received health coverage through their employer. Sixty-five percent of the Americans made the same claim in the 1991 Advisory Council on Social Security survey. Similarly, in an April, 1989 NBC survey, 29 percent of those receiving employer health coverage said their employer pays all of their health insurance premium with 69 percent receiving lesser premium benefits. In the 1991 Council's survey the figures show 33 percent receiving a full premium benefit and 65 percent receiving less.

Job Lock

A CBS/*New York Times* survey conducted in August, 1991 found that 1 in 3 American households had a family member who stayed in a job to avoid losing health coverage. The Council's survey shows a similar number, 28 percent, who report the same constraint.

Health Care As A Right

As with previous surveys, the 1991 Advisory Council on Social Security survey found that roughly 9 out of 10 Americans believe that health care is a right.

Support for National Health Reform

The Council survey found no clear preference for any one national health insurance program. Like other surveys, the Advisory Council on Social Security health care survey found that 63 percent of the people favor a Federal health insurance program while 36 percent oppose. These results are similar to a October, 1990 CBS/*New York Times* survey (64 percent favor/27 percent oppose) cited by Blendon, and a January, 1989 NBC/*Wall Street Journal* study (61 percent favor/31 percent oppose).

However, about the same proportion favored each of four other reform approaches—individual tax credits, managed care, universal protection and employer mandates. No reform approach was strongly supported by more than 14 percent.

The Social Security Survey

The Social Security survey was conducted between October 15 and 25, 1991 and included telephone interviews with 1,231 persons age 18 and older. It collected information about people's overall impressions of Social Security and related programs, their confidence in the future financing of Social Security, their views of the purpose of Social

Security and its role in their actual or expected retirement income, their views of various policy options for financing Social Security and Medicare, and their experience in contacts with the Social Security Administration.

Impressions of Social Security and Related Programs

Americans, generally report that they are familiar with the Social Security cash benefit program and have a favorable impression of it. Favorable impressions of Social Security are reported by 73 percent, while 18 percent report unfavorable impressions and 9 percent say they are unfamiliar with the program or have no opinion of it.

Medicare, Medicaid and Supplemental Security Income (SSI) were familiar to fewer Americans. Still, favorable impressions of these programs outnumbered unfavorable ones by about 3 to 1.

Predominantly favorable impressions of Social Security were reported by all age groups and ranged from a low of 67 percent for those age 25-44 to a high of 84 percent for those age 65 and older. Respondents' educational attainment and income made little difference in the favorable impressions of Social Security, with large portions of each group indicating favorable impressions of the program.

Willingness to Pay Social Security Taxes

Most Americans say they do not mind paying Social Security taxes. The overwhelming majority (78 percent) agree with the statement "I don't mind paying Social Security taxes to support the program," while 20 percent disagreed with the statement.

This measure of support rises with age, although clear majorities of all age groups indicate willingness to pay taxes to support the program. There are no significant differences in levels of support by income.

Confidence in Social Security

Confidence in the future financing of Social Security was mixed based on responses to three questions: confidence in financing respondents' own retirement benefits; confidence in financing benefits to retirees 30 years from now; and respondents views about changes in their own confidence in Social Security over the past 5 years.

Confidence in Own Future Benefits. When respondents who are not receiving Social Security benefits were asked whether they agree or disagree with the statement; "Social Security will have the money to pay benefits to me when I retire," a majority (51 percent) disagree with this statement, while 46 percent agree. This measure of confidence rises with age, but declines with educational attainment and income.

Confidence in Benefits 30 Years from Now. To standardize the time horizon about confidence in future financing, all respondents were asked whether they agree or disagree with the following statement: "Social Security will be paying benefits to those who retire 30 years from now."

In this case, a majority (51 percent) agree with the statement, while 43 percent disagree. Differences between age groups are smaller in response to this measure of confidence. Levels of confidence reported on this question are similar to results found in separate 1991 survey

conducted by the American Council on Life Insurance, which finds that about half of Americans indicate confidence in the future, while just under half do not.

Change in Confidence Over Last 5 Years. Americans tend to report a decline in confidence in Social Security over the past 5 years when asked how their own confidence has changed: 12 percent say their confidence has gotten better, 40 percent say it has stayed the same, while 46 percent say their confidence has gotten worse.

This decline in people's perception of their own confidence in Social Security contrasts with survey results of the American Council on Life Insurance, which found much lower levels of confidence in 1986 than in 1991 about the future of Social Security.

Perceptions of the Purpose of Social Security

There is some disparity between respondents' perceptions of what the purpose of the Social Security program should be, and how it works. Respondents were asked to choose which of two statements is closer to their view of what the purpose of the Social Security program should be.

Today, a narrow majority (52 percent) say that benefits alone should provide enough to meet basic needs and obligations of retired people, while 46 percent say that benefits, by themselves, should not be enough, but that together with all other sources of income, should be enough to meet basic needs. In contrast, only 19 percent believe that benefits today are enough to meet basic needs, while 73 percent say

that benefits need to be supplemented with other income in order to meet basic needs.

In general, lower income respondents are most likely and higher income respondents are least likely to say that Social Security, alone, should meet basic needs. The large majority of all income groups recognize, however, that benefits need to be supplemented in order to meet all the basic needs and obligations of retired people.

Perceived Adequacy of Retirement Income

Americans in 1991 are more likely than they were in 1979 to have positive views about the adequacy of their actual or expected retirement income. The elderly in 1991 are more likely to report that their income is enough to live comfortably (46 percent in 1991 compared to 34 percent in 1979). Fewer today say their income is not enough to pay their monthly bills (11 percent in 1991 compared to 25 percent in 1979).

Further, working age people today are more optimistic about their retirement income than were those interviewed in 1979—45 percent today say their retirement income will be enough to live comfortably, whereas only 30 percent said so in 1979. Today, just 15 percent believe their retirement income will not be enough to pay monthly bills, whereas 29 percent said so in 1991.

Optimism about the adequacy of future retirement income rose with the respondents' household income, but declined with age. Those under 25 were more likely to believe their income would be enough to

live comfortably (62 percent) than those age 45 to 54 (37 percent) or those age 55 to 65 (41 percent).

Role of Social Security in Actual or Expected Retirement Income

Despite the uncertainties they indicated about the future financing of Social Security, Americans under 65 generally expect to receive Social Security when they retire. Almost all (93 percent) said they expected Social Security to be either a major source, or a minor source of their income when they retire.

A key difference between the working-age respondents and the elderly is in the proportion who expect Social Security to be a major source of income, or the "most important" source of income.

In 1991, Social Security—

- was a major source for 68 percent of the elderly, but was expected to be a major source by 45 percent of the nonelderly; and
- was considered the "most important" source by 54 percent of the elderly, but was expected to be the most important by just 27 percent of the nonelderly.

Younger Americans often expect that their employer-sponsored pensions from private or government employee plans, or their income from assets—personal savings, investments, IRAs, Keogh plans, 401(k)

or other thrift plans—will be their most important source of retirement income.

Expectations that asset income will be the most important source of retirement income rise with household income of the respondent, but decline with age. Those age 55 to 64—who are closest to retirement—are least likely to expect income from assets to be their most important source and are the most likely to expect Social Security to be their most important source. The youngest group—those 18 to 24—have the greatest expectations that savings over their work lives will yield their most important source of retirement income.

Expected Retirement Age

In both 1979 and 1991 respondents were asked how appealing they find the idea of late retirement—that is postponing retirement to age 70. The majority in both surveys did not find the idea appealing. In 1991, however, the majority of the youngest group—18 to 24 year olds—find the idea either somewhat or very appealing, an increase over that found in 1979.

In general, the 1991 results suggest that many have not ruled out the idea of postponing retirement until age 70, but the idea has strong appeal for only a minority of working age Americans today.

Social Security and Medicare Financing Options

Respondents were asked their views about six financing options for continuing Social Security and five financing options for continuing

Medicare, if in the future, the programs did not have enough funds to pay promised benefits. All 11 of the options involved either raising taxes or reducing Social Security or Medicare benefits. Of the 11 options, 3 received support from a majority of respondents. They include:

- "change the law so that all earnings over \$53,000 are subject to Social Security taxes," which was approved by 77 percent and disapproved by 18 percent.
- "reduce (Social Security) benefits for people whose incomes are above a certain level," which was approved by 64 percent and disapproved by 32 percent.
- "make higher income people pay more for their Medicare premium," which was approved by 50 percent and opposed by 47 percent.

Unlike the other options offered, these tend to affect primarily upper income workers or beneficiaries.

Continuing Social Security

After considering the Social Security financing options, the majority (58 percent) of respondents agreed the statement: "The Social Security program should be continued pretty much as is," while 39 percent disagreed. The large majority of those who disagreed said the program should be "modified" (34 percent) rather than "abolished" (2 percent) or "replaced with something else" (2 percent).

When offered an opportunity, in an open ended question, to say how they thought Social Security should be modified, some expressed concern about future financing, but were unsure what to do about it. Some reiterated themes covered earlier in the interview: They wished benefits would meet basic needs for the elderly, or they wished that upper income persons would pay more or receive less so that lower income groups could receive more. Others, however, said that individuals' benefits should be more closely related to what they had paid in. Some raised concerns that had not been covered earlier in the interview—for example, that Social Security funds should not be used to pay for other government programs.

Administrative Costs

When asked (separately for Social Security and Medicare): "What percentage of the Social Security (Medicare) tax dollars collected do you think goes to paying benefits as opposed to administrative or other expenses?" most Americans indicated they believe that far less is paid out in benefits than is collected in taxes. In all age, education, and income groups the majority of respondents who had an opinion thought that only 25 to 75 percent of the money collected is used to pay benefits, as opposed to administrative or other expenses.

That perception is very different from the actual operations of the programs. Benefits represent about 99 percent of all expenditures from the Social Security trust funds and about 98 percent of Medicare trust fund expenditures.

As a share of total income collected in taxes (and Medicare premiums), benefit are about 88 percent for Social Security and

90 percent for the Hospital Insurance component (HI) of Medicare in 1991. A small minority of respondents (fewer than 10 percent) reported they thought the ratio of benefits payments to money collected was this high.

The Health Care Survey

The Advisory Council's health care survey was conducted between October 27 and November 6, 1991. This survey measured knowledge about the system as well as experience and perceptions, support and opposition for proposals to change the health care system, and opinion on financing options to provide health care for the uninsured.

This represents one of the most comprehensive health surveys ever undertaken. Further, it examines, in detail, all major proposals for changing the health care system. In addition, the survey went beyond tests of overall support for these proposals and measured public attitudes toward the key components of the plans. Also, statistical analyses were run to determine the importance of each concept. The key findings are as follows:

- Americans' knowledge of the health care system is limited. Although a majority of Americans are aware that Medicare doesn't cover lengthy stays in nursing homes and can correctly identify a statement describing the overall Medicare program, a majority cannot describe the Medicaid program. Only 25 percent know the approximate annual level of national health care expenditure, and just one-third give the correct range of the

national health expenditure that is covered by private health insurance.

Further, there is a strong tendency to overestimate the number of uninsured people. Only 7 percent know the total number of uninsured people in the country. A majority (52 percent) estimate the number at more than 50 million and 27 percent say that more than 100 million Americans are without health insurance at some point during the year.

- A majority of Americans (62 percent) do not believe that major changes are needed in the health care system to meet their personal needs. As a result, 52 percent say their needs are met and 10 percent say minor changes are needed. At the same time, six out of ten Americans when asked about specific reform proposals favored a change in the system. Americans exhibit both a desire for change and satisfaction with the status quo—presenting a real dilemma for policy makers. A number of factors are involved.
 - Desire for change increases with dissatisfaction with health care services, health insurance coverage, the costs associated with health insurance, or lack of confidence in the adequacy of health insurance to meet a major health expense.
 - A large majority of those under age 65 who have private health insurance, however, are satisfied with both their health care services (78 percent) and their health insurance coverage (78 percent).

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- A majority of Americans (66 percent) are confident that they have adequate health insurance to meet the cost of a major medical expense while 33 percent are not. Low confidence is more prevalent among those earning less than \$20,000 annually. Confidence in the adequacy of health insurance contributes significantly to desire for change.
 - A majority (72 percent) agree with the statement "Changing our health care system would cost everyone more money either in higher taxes or in higher personal health care costs. Forty percent *strongly* agree. There is virtually no difference by region or age. However, those who are most likely to desire change in the health care system are the least likely to agree that change will cost everyone more money.

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- Five major proposals for changing the health care system were tested in this survey. These include:

A Total Federal Program	a national health care system run by the Federal government and paid for by Federal taxes;
Managed Care Proposal	an arrangement that essentially is the same financing mechanism as in today's system but with a managed care HMO-style scenario;
Employer Mandates	employers would be required to provide a basic package of health insurance for their employees or pay a special tax so that the government could provide a health insurance plan for basic services;
Universal Protection Proposal	a new type of coverage would pay all medical bills in excess of 20 percent of annual income and where the government would provide health insurance for the poor; and;
Individual Tax Credit Proposal	people would get tax breaks for purchasing insurance and employees could choose between their employer's plan and other plans.

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- Americans do not have strongly-held preferences for any of the proposals for changing the health care system. As a result, people are willing to examine options but are not locked into them. This is evidenced by the fact that majorities "somewhat" favor or oppose each of the proposals for changing the health care system, while few strongly favor or oppose them. Only a small percentage (16 percent) favor all proposals and not more than 14 percent strongly favor any proposal, and attitudes toward one plan do not predict attitudes toward another. The components of the proposals themselves contribute more to our understanding of support than other attitudes and demographics.
 - People give high ratings to options that would expand coverage, and low ratings to payment mechanisms and program limitations. Negative ratings are reserved mainly for items that describe the cost of programs, waiting lists, the need for referrals, and limitations on coverage. This finding is consistent with Blendon's 1990 special report. However, our regression analyses also reveal that items that are especially well-liked or disliked are not necessarily important as factors driving support for, or opposition to, the overall proposal.
 - The results show that there is no clear preference for any one proposal over another. Each proposal receives roughly the same average level of support. Further, although a majority of respondents favor each option, enthusiasm for these options is not strong. Most people say they "somewhat favor" the options rather than "strongly favor" them. In fact, the highest "strongly favor" percentage is 14 percent. In some cases as many people

"strongly oppose" as "strongly favor" an option. The distribution of responses is as follows:

	Total Favor	Total Oppose	Strongly Favor	Strongly Oppose	MEAN*
Total Federal Program	63%	36%	14%	13%	2.7
Managed Care	58%	41%	14%	15%	2.6
Employer Mandates	59%	40%	11%	13%	2.6
Universal Protection	71%	27%	13%	6%	2.8
Individual Tax Credits	65%	34%	11%	8%	2.7

*Mean rating based on a 1-4 scale where 1=Strongly oppose and 4=strongly favor.

There were few differences in the level of support for these options among demographic groups based on age, sex, income, and region. Nor does desire for change drive support or opposition to these options. Rather, the factors driving support or opposition to these options appear to be the components of the options themselves, although satisfaction and confidence in health insurance, willingness to pay for the uninsured, and other associated variables make minor contributions to understanding support.

- An overwhelming majority (81 percent) of those with children under the age of 12 say they would take their children to school-based health centers at or near elementary schools. In these centers, doctors and nurses would see children to provide physical examinations, immunizations, screening for illness, and

vision and hearing tests. Further, a majority of all respondents say that these centers should also provide education and counseling to prevent alcohol and drug abuse for elementary school children.

THE INTERIM REPORT ON SOCIAL SECURITY AND THE FEDERAL BUDGET

On questions of Social Security financing and the relationship of the trust fund buildup to the Federal budget, the Council finds that:

- The Social Security (OASDI) tax on earnings is an appropriate way to pay for Social Security benefits.
- The Social Security system is adequately financed for the next several decades.
- The cost of OASDI will rise beginning with the retirement of the baby boom generation.
- The increase in the cost of Social Security that occurs as the baby boom generation retires is not expected to decline as succeeding generations retire.
- The best way to ease the burden of paying for future retirement benefits is to increase the productive capacity of the economy.
- Persistent large deficits in the Federal budget impede the Nation's ability to invest in the future productive capacity of the economy.
- The buildup of reserves in the OASDI trust funds will not reduce the burden or costs of Social Security in the future unless it is used in ways that help promote economic growth.

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- The buildup of OASDI reserves, on the other hand, can help reduce the burden of supporting future retirees if the buildup increases funds available for investment to promote economic growth.

Based on these findings, the Council makes the following recommendations:

Recommendation 1: The Council believes it is important to move from large Federal deficits to achieve surpluses in the total Federal budget in order to provide for a strong economy when the large baby boom generation retires. The Council supports removing Social Security from the calculation of deficit reduction targets to focus public attention on the importance of reducing the deficit in the rest of the budget in order to achieve this goal.

Recommendation 2: The Council recommends that no action now be taken to reduce revenues to the OASDI trust funds.

Recommendation 3: The Council supports the continuation of partial reserve financing of Old-Age, Survivors, and Disability Insurance and at the same time urges a major reduction in the deficit in the non-Social Security portion of the Federal budget.

Recommendation 4: The Council recommends continuation of the current policy of investing OASDI reserves in interest-bearing U.S. Treasury securities that are guaranteed as to principal and interest by the U.S. Government.

CRITICAL ISSUES IN AMERICAN HEALTH CARE DELIVERY AND FINANCING POLICY

The focus of the 1991 Advisory Council on Social Security covered the waterfront in health care—the solvency of the Medicare Trust Funds; the adequacy of the Medicare and Medicaid programs; access to health care for the uninsured; long-term care; and an examination of the range and scope of the problem of rising health care costs and its implications for the economy and for individuals.

This Report contains 18 separate papers that served as background briefing documents to guide Council discussion on issues related to health care reform. These papers represent the most current research of the issues that are important in the 1990s in considering any redesign of our health care financing and delivery system. They are intended to provide a historical perspective as well as to provide guidance for future debates on health care policy.

The document contains papers covering three different areas—access to care, cost containment, and health care financing and delivery in other countries. Following is a listing of the papers and a short description of each.

Access to Care Papers

These papers describe the current health care financing and delivery system and the gaps in the system for persons who are uninsured and

underinsured. The papers then present a range of incremental options that have been widely discussed for expanding access to care.

Profile of the Uninsured and Underinsured

Most estimates place the number of Americans lacking public or private health insurance coverage between 31 and 36 million. Many millions more have coverage which does not meet their health care needs. Fashioning proposals to address the needs of the uninsured and underinsured requires an understanding of the number and characteristics of these populations. This paper describes the size and characteristics of the uninsured and underinsured populations and examines the consequences of no insurance in terms of access to care and the cost of health care.

Private Health Insurance

For the great majority of Americans, private health insurance (both employment-based and self-purchased) is the primary source of financing for health care. Three-quarters of Americans younger than age 65 are covered by some form of private health insurance. Over two-thirds are covered by employer-sponsored plans. Approximately 14 million people younger than age 65 are covered by insurance bought by individuals. As policy-makers consider options for increasing access to health care for Americans currently without health insurance, it is important to understand the potential—and limitations—of the private market for health insurance as a mechanism for expanding coverage. This paper describes the growth and structure of private health insurance in the United States. It then presents the

major issues confronting the private health insurance market and the implications for coverage.

Public Health Insurance

Through the creation of the Medicare and Medicaid programs, the Federal Government became a major payer for health services in the United States. Both Medicare and Medicaid were established to cover populations considered unable to obtain private health insurance to meet their needs. Since their enactment in 1965, these public programs have grown dramatically in size and scope, today providing coverage to about 58 million persons. The role of public insurance in meeting the Nation's health care needs has received renewed interest as the problems of access to care and rising health care costs have intensified. Questions are being raised about the potential for reforming to meet the needs of a broader population including the currently uninsured. This paper presents an overview of the Medicare and Medicaid programs, their limitations in providing health care coverage, and their role in health care reform.

The Role of Direct-Financed Services

Direct service providers play an important role in health care delivery in the United States, even though their budgets represented a small proportion of the over \$600 billion spent on personal health care expenditures in 1990. Many Americans receive a significant amount of health care from providers who are directly financed by Federal, State and local governments and private foundations to deliver health care to specific populations. Direct service providers are characterized as those who receive public and/or private monies to serve specific

populations or who offer a defined set of services. These providers include government-owned and operated hospitals and clinics and not-for-profit health centers supported by grant funds. Specific targeted groups include military personnel, veterans, pregnant women, infants, children, the elderly, persons with disabilities, and minorities. Special services include maternal and child health care, substance abuse and mental health services, and immunizations. This paper describes the major providers and sources of funding for direct services and examines the role of direct services in health care reform.

The Problem of Long-Term Care

Five major problems affect the United States' long-term care financing and delivery system. These problems include: the catastrophic costs of long-term care; the lack of public or private risk pooling; variation and lack of access; questionable quality of long-term care services; and high and increasing long-term care expenditures. This paper briefly discusses each of these problems as well as the factors that contribute to each problem and the consequences of each problem.

Health Insurance Reform for Small Employers and High-Risk Individuals

With about one-third of uninsured workers and their dependents employed by firms with fewer than 25 employees, widespread attention has focused on the small employer market for health insurance. Small employers may be denied health insurance or face higher premiums than larger groups for comparable coverage. This paper reviews the six major categories of health insurance reform proposals and their implications for coverage. The categories include

small employer market reforms; private reinsurance; mandatory community rating risk pools for uninsurable individuals; affordable coverage for small employer groups; and tax assistance for small employers.

Medicaid Expansion

Many of the major health care reform proposals that call for universal coverage include a prominent role for Medicaid, typically as a complement to expanded employment-based insurance. At both the State and Federal levels, Medicaid expansions have been implemented as a means of improving access to care for vulnerable or at-risk groups, such as low-income pregnant women and young children. Expansion of Medicaid may occur along several dimensions: eligibility, services, and reimbursement. Although the impact of expansions in terms of improved access is not yet clear, it is evident that the cost implications for States have been high and increasingly burdensome. The difficulty with Medicaid expansion/reform is finding an acceptable balance between expanded access and cost. This paper describes proposals for Medicaid expansion and their potential impact in these two areas.

The Role of Schools in Expanding Access to Care

The significant relationship between health and school performance is well established. Educators and parents alike recognize that children who are healthy are more likely to attend school on a regular basis and function productively in the classroom. As a result, schools are becoming increasingly involved in developing comprehensive school health programs designed to promote healthy behaviors among school

children. This paper discusses the role schools can play in expanding access to care and how these efforts might be financed.

State Initiatives to Expand Access to Care

Over a dozen universal health insurance proposals are being considered by State legislatures, and even more commissions and task forces have been established to study the issue. Three States have enacted programs to achieve universal coverage, while a number of States have implemented incremental approaches targeted toward particular segments of the population. State fiscal crises have slowed implementation of these initiatives. Many States are now finding it difficult to meet their commitments to current programs and are reluctant to undertake new reform efforts. States do not believe they can expand access to care without first gaining control over spiraling health care costs. This paper describes the reform options that have been enacted or are being considered at the State level. It first discusses the universal reform proposals and then presents the targeted reform options which have been adopted.

Options for Financing Long-Term Care

The financing and delivery of long-term care services pose challenging public policy dilemmas. This paper presents a brief review of some of the major problems of long-term care, including catastrophic costs, the lack of risk pooling, variation and lack of access to services, questionable quality of some services, and high and increasing expenditures. It then presents a framework for assessing long-term care reform options. A number of public, private, and combined public/private options are then described. The public options

discussed are Medicaid reform, comprehensive social insurance, front-end nursing home coverage, back-end nursing home coverage, and expanded home care. The private options described are Individual Medical Accounts, incentives for long-term care insurance purchase, accelerated death benefits, and use of pension funds. The combined public/private options are Medicaid Spenddown Insurance, voluntary Medicare insurance, and combined Medicare acute/long-term care coverage. The paper concludes by applying the framework to several of these reform initiatives.

Approaches for Financing Expansions in Access to Care

Many of these recent health care reform proposals for expanding access to care would involve increased Federal spending on health care. However, little attention has been paid to how these new programs (or extensions to existing programs) will be financed. This paper addresses eight different sources of financing: payroll taxes; personal income taxes; taxing some employer-provided health insurance benefits as income; a value-added tax (VAT); "sin" taxes, such as excise taxes on gasoline, alcohol, and tobacco; national lotteries; "user" taxes, so that those covered in a new program pay a disproportionate share of the program's costs; and estate and gift taxes. These eight alternatives have been considered in financing health care reform because they can be easily integrated into the existing tax system and because they raise substantial amounts of revenue. The paper begins with a discussion of the projected costs of some of the current health care initiatives. Understanding the size of these costs provides some context for considering the various revenue proposals. Next, a framework for analyzing the different financing approaches is

presented, which considers (1) how much net revenue the alternative could raise; (2) how each alternative affects economic and personal incentives; and (3) issues of fairness and equity—will certain groups, particularly the poor, contribute a disproportionate share of these new revenues? The paper concludes with an analysis of each of the eight alternatives within the framework.

Cost-Containment Papers

With health care cost containment emerging as a national priority, these papers discuss the problem of rising health care costs, the experience of efforts to contain costs, and the impact of cost containment on quality of care.

The Problem of Rising Health Care Costs

The rise in health care spending has become a serious and persistent national concern. Health spending between 1976 and 1990 increased by more than twice the rate of growth of the economy. Because this rate of growth has exceeded the rise in the Gross Domestic Product, the fraction of our resources devoted to health care spending also increases every year; it is currently projected to reach 17 percent of GNP by the year 2000. This rise in spending cannot be sustained indefinitely. Concern over this issue has resulted in calls from business, government, and consumers for limits on health care spending. However, many questions about controlling health spending remain unanswered. What composes the current level of health care spending? Why is spending rising so quickly? This paper addresses each of these questions.

Controlling the Costs of Administration

The costs of administering the U.S. health care system have been the subject of much recent debate. Many believe that administrative costs are excessive and that they contribute to rising health care costs and high rates of uninsurance. Administrative costs have become the target of those who believe that by reducing these costs, the United States can decrease significantly the amount spent on health care without further eroding access or adopting draconian cost-containment measures. At the center of the debate over administrative costs is the question of how much pluralism in the health care system we are willing to pay for. The costs of administering a health care system with multiple payers does cost more than a single-payer system but no agreement has been reached on how much more. In addition, the full costs and benefits of pluralism compared with a single payer approach have not been adequately addressed in the debate over administrative costs. This paper examines the costs of administering the U.S. health care system and the role that administrative costs are playing in the health care reform debate.

Containing Health Care Costs Through Supply and Price Controls

Policymakers have renewed interest in developing cost-containment initiatives to slow the rise in health care costs. Prior efforts to curb rising health care costs have been sporadic and only marginally successful. Most attempts to control spending have focused on one payer (e.g., Medicare) or on certain providers (e.g., hospitals), and while they have been effective in certain parts of the health care system, they have been unsuccessful in slowing the rise in total health

spending. The failure to control increases in total health spending may be explained by the two following factors. First, efforts that achieved some costs savings in one segment of the health care system usually resulted in cost shifting to other segments, producing total aggregate increases in overall health care spending. Second, efforts to control costs were often marked by an absence of "will" to make tough decisions regarding the control of services and technology. This paper examines the efforts to contain health care costs in the United States through supply and price controls, many of which have been established at the Federal and State level over the past 15 years. Specifically, the paper examines the experience and effectiveness in controlling costs; health planning and Certificate of Need; State rate-setting programs; the Medicare Prospective Payment System; and controls on expenditures.

Managed Care as a Cost-Containment Vehicle

Managed care is increasingly seen as a mechanism both for limiting prices paid to providers and for restraining excessive utilization of health services. While managed care has been advocated by some as a solution to the Nation's health cost problems for 20 years, it is only recently that managed care has garnered a wide constituency and has become a large, mature industry which touches a significant proportion of both the privately and publicly insured population. This paper describes the fundamental elements of managed care as a cost-containment vehicle. It begins by defining the concept of managed care and provides an overview of the principal managed-care strategies employed by purchasers of health care. It then follows with a more indepth description and analysis of the specific managed-care programs which comprise each primary strategy.

Health Care Rationing

Health care rationing has emerged as one of the most difficult and pressing social questions of our time. Interest in the potential to control spending through rationing of care has been prompted by the lack of success of efforts to control overall spending on health care. Recent interest has also been stimulated by the efforts of the State of Oregon to implement a program which would explicitly ration health services to those insured under Medicaid. There are essentially two methods by which health care resources can be allocated: price rationing and "non-price" rationing. In price rationing, already common in the United States, health care is rationed on the basis of price. This paper presents a number of studies which indicate that patients without an ability to pay receive less care than those who are well-insured. Non-price rationing, the focus of this paper, occurs when even those with an ability to pay for care are not allowed to do so. Although non-price rationing has not been broadly applied in the United States, it appears to be a regular feature of health care systems in some industrialized nations. The paper begins with a discussion of the debate over whether health care rationing will be necessary. It goes on to discuss the many difficult and complex logistical, legal, and ethical problems associated with non-price rationing. The paper concludes by considering the likely future of health care rationing in this country.

Cost Containment and Quality of Care

General agreement exists that the United States spends too much on health care relative to consumer perceptions of value. It is also recognized that some of the care delivered is unnecessary or of low

benefit. Many existing cost-containment strategies are intended to eliminate unnecessary and low benefit care while preserving care that is of value. The question posed by many policy-makers is the extent to which these approaches have successfully targeted waste and inefficiency or whether quality of care has been jeopardized. This paper examines the evidence of the impact on cost and quality of care of two strategies: (1) incentives to influence provider behaviors such as provider reimbursement incentives designed to influence providers to use fewer resources and (2) incentives to influence consumers such as increased patient cost-sharing. The paper begins by defining quality of care and discussing the approaches to measure quality. It goes on to discuss the relationship between cost and quality and concludes by reviewing the impact of provider payment incentives and consumer behavior incentives on the quality of care.

Health Care Financing and Delivery in Other Countries

The large number of uninsured persons and increasing health care expenditures in the United States have led policymakers and consumers alike to examine the delivery systems of other countries, primarily because they provide universal care while spending less. This paper provides an overview of the health care delivery systems of four foreign countries and examines their approaches to containing health care costs while attempting to maintain access and quality of care. It also explores consumer perceptions of how well the various systems are working and what difficulties there may be in transferring aspects of foreign delivery systems into the United States. The countries profiled are Canada, the United Kingdom, Germany, and France.

FUTURE FINANCIAL RESOURCES OF THE ELDERLY: A VIEW OF PENSIONS, SAVINGS, SOCIAL SECURITY, AND EARNINGS IN THE 21ST CENTURY

Income Today

Examining retirement income policy options requires an understanding of the expected level of financial resources of the elderly in the future under current law.⁴ Comparing the financial resources of today's elderly to the financial resources of the elderly in 30 years highlights the following two significant findings:

- the economic status of the elderly is expected to improve; and
- with the exception of pensions, the roles of different income sources will remain similar to those for the elderly today.

Currently, the primary sources of income for elderly families are Social Security benefits and asset income. (See table ES.1.) Over 90 percent of elderly families receive Social Security benefits, with the median level being \$7,590. Social Security is the single largest source of income for elderly families, accounting for a little over 40 percent of total income.

⁴ The estimates of income and wealth presented in this paper are based on results from the Pension and Retirement Income Simulation Model (PRISM). PRISM is a microsimulation model which simulates the economic status of the elderly during the period 1988 to 2018. The model simulates income from both public and private sources, as well as home equity and financial asset holdings.

TABLE ES.1
CURRENT INCOME OF THE ELDERLY, 1988
(in 1988 dollars)

Income Source	Percent of Elderly Families with Income Source	Median Income from Source for Families with Source	Share of Aggregate Income Contributed by Source
Social Security	92%	\$7,590	41%
Private Pensions	40%	\$4,730	17%
Earnings	19%	\$11,940	17%
Asset	73%	\$890	24%
Other	11%	\$2,000	1%
TOTAL	100%	\$11,750	100%

SOURCE: Lewin/ICF estimates based on the Pension and Retirement Income Simulation Model (PRISM), 1991.

Asset income makes up the second largest share of income for the elderly; it provides nearly one-quarter of aggregate income. (See table ES.1.) Income from assets makes up a much larger share of the total income of moderate and higher income elderly families than it does for lower income families. The share of income from assets for higher income elderly families (those with income at or above 300 percent of the poverty

level) is over six times as high as the share for lower income families (those with income less than 150 percent of the poverty level) (32 percent versus 5 percent).

Income in 2018

Both the income and wealth of the elderly are expected to increase over the next 30 years. PRISM simulations indicate that family incomes of the elderly are expected to increase by almost 50 percent in real terms (1988 dollars), going from an average of \$18,220 in 1988 to \$26,780 in 2018. (See table ES.2.) Median family income is expected to increase by nearly 60 percent over this 30-year period.

Poverty rates, a measure of the relative proportion of the poorest elderly over time, are expected to decline to approximately 7 percent by 2018 under the assumptions used here.⁵ This continues a trend which began in the 1960's, when the percentage of non-institutionalized elderly persons in poverty fell from over 35 percent in 1959 to 29 percent in 1966 to 12 percent in 1990.⁶

According to table ES.2, the 1.3 percent annual real increase in the average income of elderly families will be higher than the assumed increases in real wages over the period (approximately 1.1 percent

⁵ Estimates of the number of persons in poverty based on PRISM tend to be somewhat higher than estimates developed by the Census Bureau due to the definitional differences in forming family units and the inclusion of institutionalized persons in the PRISM estimates.

⁶ Committee on Ways and Means, U.S. House of Representatives, *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, Washington, D.C., March 1991, p. 1102 and Bureau of the Census News Release, September 1991. The 12 percent of elderly below poverty in 1990 actually reverses the downward trend, rising from 11.4 percent in 1989.

TABLE ES.2**AVERAGE AND MEDIAN ELDERLY FAMILY INCOME, 1988 AND 2018**
(in 1988 dollars)

	1988	2018	Percent Change	Annual Percent Change
Average Family Income	\$18,220	\$26,780	47%	1.3%
Median Family Income	\$11,770	\$18,760	59%	1.6%

SOURCE: Lewin/ICF estimates based on the Pension and Retirement Income Simulation Model (PRISM), 1991.

annually). The receipt of income from more sources—particularly pension income, which more elderly families will receive—is the driving factor behind a rate of increase greater than that of real wages. However, the increased role of pensions in the income of the elderly is not guaranteed because of the many uncertainties about pensions.

It is important to keep in mind that the projections presented here attempt to predict the behavior of retirees 30 years in the future based on the best available knowledge of relevant behavior today and a large set of assumptions about the economy. To the degree that these assumptions are not met, or that future generations behave differently than the current retired population, the results of the analysis will differ.

SOCIAL SECURITY AND THE FUTURE FINANCIAL SECURITY OF WOMEN

Purpose of this Report

Over its history, the Social Security program has responded to the changing economic and social conditions in the United States and the changing needs of Social Security beneficiaries. Recently, an increasing amount of attention has been devoted to the Social Security benefits paid to women as (1) more women (including married women and women with children) enter and remain in the labor force; and (2) the incomes and assets of elderly single women (particularly elderly widows) continue to lag behind the incomes and assets of elderly couples and single elderly men.

This report is designed to address these issues. In particular, this report focuses on three primary topics:

- Social Security's current methods for determining the benefits paid to women;
- A comparison of the recent (1988) and future (2018) incomes and assets of elderly single women, elderly couples, and elderly single men; and,
- Current public perceptions of the adequacy of Social Security benefits for women and public suggestions for changing Social Security benefit computation formulas for women.

Social Security and Women

Social Security attempts to fulfill two sometimes competing goals: providing adequate and equitable benefits to its beneficiaries, including women. To provide more adequate benefits, Social Security provides proportionately higher benefits to those with lower lifetime earnings than those with higher earnings. At the same time, benefit equity is not ignored because the absolute size of Social Security benefits increases as lifetime earnings rise.

By law, Social Security benefits are computed in a gender-neutral fashion. In practice, women commonly receive lower Social Security benefits than men. The benefits women receive are lower because women tend to work for lower wages and have more frequent absences from the labor force. Elderly men also tend to die before their wives. While both members of an elderly couple are alive, the couple receives the larger of one and one-half times the benefit based on the higher of the couple's lifetime earnings (which is usually the earnings of the husband) or the total benefits based on each spouse's lifetime earnings. At the death of one spouse, however, the surviving spouse is entitled to only the benefits based on the higher of the two spouses' lifetime earnings. If both members of the couple have the same lifetime earnings, the surviving spouse will see the couple's benefit cut in half.

The Income and Wealth of Elderly Women in 1988 and 2018

This report presents estimates of the income and wealth of five different elderly groups in 1988 and 2018: (1) all elderly, (2) elderly couples, (3) all elderly single individuals, (4) single elderly men, and (5) single elderly women, for three different age groups: (1) 65 to 74, (2) 75 to 84, and (3) 85 and above.

In comparing these estimates of the income and wealth of elderly single women with other elderly groups in 1988 and 2018, three major themes emerge:

- The economic status of elderly women is expected to improve;
- Single elderly women have lower levels of income and wealth than other elderly groups, particularly couples, and these differences will continue in the future; and,
- The economic well-being of elderly single persons will decline relative to that of elderly couples.

Input From the Public

The Advisory Council on Social Security conducted hearings, collected testimony from several sources, and commissioned a survey of current attitudes about Social Security. The testimony from the public hearings and the results of the survey both indicated that the public

would like to see the Social Security benefits of women increase. In particular, the public favors increasing the Social Security benefits of women who leave the labor force to care for their children or their disabled relatives. It also favors basing the Social Security benefits paid to widows on two-thirds of the combined benefits the couple received prior to the husband's death.

THE INFLUENCE OF CURRENT JUDICIAL DOCTRINES ON THE COST OF PURCHASING HEALTH CARE

Five sorts of litigation against the health care industry—physicians, hospitals, health plans, insurers, and product manufacturers—bear significantly on the costs of obtaining health care.

I.

Suits over coverage under contracts of health insurance involve, in the main, a contention by the insured that a treatment is "reasonable and necessary" to alleviate his ailment; the insurer contends, to the contrary, that it falls under a general exclusion for treatments that are "experimental or investigational." Although the test of these contentions is current medical practice—whether a treatment is accepted within the profession—some courts have decided these cases on the basis of evidence that the treatment, although not accepted, is effective.

An insured may also, in some cases, avoid the issue altogether by suing for a preliminary injunction. If he shows that a refusal to cover treatment would cause him irreparable harm, and that he has at least some argument that the treatment is not experimental (or is effective), the court may require the company to pay for the treatment pending the outcome of the litigation.

The insured is aided by several legal doctrines that read insurance contracts for the benefit of the insured, and construe ambiguities against the insurer.

As a result of a major shift, in 1989, in the doctrines applied by the Federal courts to suits under the Employment Retirement Income Security Act, the Federal courts now decide ERISA suits much like State courts acting under State law.

There is no way in which an insurance company can readily anticipate these decisions, which tend to extend coverage for the most expensive technologies, except by building large margins into its premium structure. This has two effects: (1) it increases the costs of health care, as a share of the gross national product, by extending existing insurance to additional services; and (2) it may reduce the availability of health insurance, thereby tending to lower the national costs of health care, as a share of the GNP, because some health care services will no longer be available to persons who can no longer afford to pay for them.

Note that the increased insurance premium does pay for a real economic good: broader coverage. Therefore, subject to the fluctuations of supply and demand (to the extent they operate in the health care market), coverage decisions should be relatively neutral in their effect on the base price of services.

II.

Malpractice claims are based on a patient's contention that the negligent failure of his health care provider to adhere to current standards of medical care—usually an error in diagnosis, evaluation and treatment, prescribing and dosing, procedure, or communication—caused the adverse outcome of his medical treatment.

The most significant malpractice issue of recent years has involved the question of a physician's liability when, against his better judgment, he takes a course of action directed under a system of managed care. In a leading case, the California Court of Appeals upheld such a direction as within acceptable medical standards, even though in the circumstances it led to patient injury. But the court observed that a third-party payer would be liable for erroneous medical decisions resulting from its actions, and a physician cannot shift legal responsibility for his patient's welfare to a third-party payer by complying with the directives of a cost containment program.

The 1980's saw a vast increase in the frequency and size of malpractice claims, engendering what has been described as a "crisis" in the cost of professional liability insurance. In response, some states enacted statutes to limit the amount of recovery in malpractice claims (or cap non-economic damages, such as for pain and suffering), require that the claims be submitted to a pretrial panel, require awards to be offset by insurance, or shorten the period during which a claim may be filed after the injury. Several of these statutes have been successfully attacked on the constitutional ground of equal protection, i.e., that they arbitrarily create a disfavored class of litigants.

The effect of malpractice decisions has been to drive up the costs of professional liability insurance premiums at an average annual rate, since 1985, of 13.9 percent for all physicians, with the average nationwide professional liability premium in 1989 at \$15,500. This represented, for all self-employed physicians, 4.9 percent of total practice revenues.

Within this average, the distribution moves from a high of \$37,000 for obstetricians and gynecologists (9 percent of practice revenues) to a low of \$5,500 for pathologists (2.1 percent of revenues). But evidence suggests that physicians have not been able to pass all of these increases on to their patients through increased fees.

In devising a legislative approach to the question of limiting the effect of malpractice awards on the cost of health care, the policy maker must distinguish between two components of an award: direct damages and consequential damages.

Consequential damages—pain and suffering, punitive damages, loss of consortium, and the like—are not to compensate the claimant for economic losses. Their size is necessarily arbitrary. It can be argued that a rationale for limiting their size—albeit by another arbitrary amount—is that the health care system can no longer afford the costs of what, to a plaintiff who is, in any event, to be compensated for real economic loss, is a financial windfall.

Direct damages—actual economic loss or additional expense that malpractice inflicts on an individual—raises a policy issue of a different sort. Beyond the expense to an individual in obtaining health care, there is the expense that the care may inflict upon him. A

malpractice award of direct damages is intended to compensate him for this economic loss by spreading it, through malpractice premiums, to the health care system at large. Here, a decision to limit the size of the award must be based on the more difficult judgment that the public interest requires an individual personally to bear some significant portion of that loss.

Although the components of a malpractice award are reasonably clear in a malpractice case, they are far more difficult to distinguish in the mass of settlements that never reach the courts. If one disregards the outliers, consequential damages, in the average case not involving permanent loss of earnings, are between three and four times the amount of direct damages.

Finally, in estimating the costs of judicial doctrines in professional liability cases, there is the cost of "defensive medicine." Because professional standards are vague, and physicians are sometimes confused as to the standards to which a court may hold them, there is a tendency in the medical profession to employ procedures that a physician considers necessary solely to avoid the threat of malpractice litigation.

Inasmuch as the standards that a court applies in a malpractice case are those, insofar as they can be ascertained, of the medical profession itself, some portion of this "defensive medicine" is likely to be unnecessary to protect the physician. Another portion, although perhaps thought unnecessary by the physician employing it, is considered good and desirable medical practice by some sample of his peers.

The problem for physicians, as Clark Havighurst has pointed out, is that the courts, by judicial fiat, have imposed upon them, regardless of the individual circumstances of the physician or his patients, the highest standards of the profession.

How much of defensive medicine is truly unnecessary to protect against a malpractice action, and how much cost that adds to patient charges, is not known.

III.

Litigation over injury caused by prescription drugs and medical devices is governed by State law that, in general, imposes an absolute liability on manufacturers for "defective" products, i.e., products that cause unanticipated and unwarned-of injurious effects. The volume of these cases is dramatically affected by the major manufacturer/single product "epidemic" cases, such as the litigation over the Dalkon Shield and Bendectin. But even if these are disregarded, the number of health product liability cases grew steadily throughout the 1980's at a rate that far exceeded that for other product liability litigation.

One estimate puts the cost of medical device product liability at about four percent of the sale price of every medical device, compared to an earlier estimate for manufacturing firms generally of less than one percent.

The major cost of product liability to the health care system is probably the hidden cost: high-risk products that are not developed because the dangers of litigation exceed the potential for profit.

IV.

Litigation to terminate medical treatment has burgeoned in response to the growing ability of medical science to prolong life beyond the desires of those receiving care. In general, the present state of the law in this area supports the unqualified right of a competent individual to refuse medical care, including artificial nutrition and hydration, even if the individual is not suffering from a terminal illness.

In the case of an individual who is not competent, the usual practice is to permit a guardian or family member to exercise the right on his behalf. But the standard is one of "substituted judgment." That is, the court must be persuaded that the decision to withdraw care is one that the individual himself would have taken if he were competent. In at least one jurisdiction, Missouri, this standard can only be met by clear and convincing evidence of intentions expressed by the individual while competent. Other jurisdictions are generally less exacting.

Because of the growth of the aged population—68 million people will be over age 65 by the year 2040, and 12.2 million will be over age 85—and the exponential increase in medical costs as individuals enter the last decades of life, the exercise of the right to refuse medical care will bear increasingly on the national costs of health care. How much its exercise will offset the rising expense of new technology to prolong life even further is speculative.

V.

Antitrust suits to prevent or reverse mergers and acquisitions by health care providers are usually conducted by the Justice Department and the Federal Trade Commission, although private action is not unknown.

The governing law is complex, and is summarized below in the pertinent section of this report. The basic objective of these cases is to interdict a provider's acquisition of "market power" (i.e., the ability of a seller profitably to restrict output and raise prices above competitive levels without losing a large part of its business).

The economic implications for health care providers are unclear. Certainly, antitrust actions interfere with efficiencies in service delivery that could reduce both the price of services and the costs of the health care system. But they also interfere with market concentration that, at least in the opinion of the Justice Department, the Federal Trade Commission, and the courts, would increase those prices and costs.

STATE GOVERNMENTS: THE EFFECTS OF HEALTH CARE PROGRAM EXPANSION IN A PERIOD OF FISCAL STRESS

Ten years ago, the Medicaid program was an important part of a multifaceted intergovernmental system. For example, 1979 Federal expenditures on Medicaid were \$12.4 billion, 2.5 percent of the Federal budget, while spending for Comprehensive Employment and Training Act (CETA) programs was \$8.7 billion. Transportation grants (highway, mass transit, and airports) totalled \$10.4 billion, general revenue sharing expended \$6.8 billion, and spending for Aid to Families with Dependent Children (AFDC) and related programs was \$6.3 billion annually. Grants-in-aid to State and local governments totalled \$82.9 billion, 16.5 percent of Federal spending.

By 1989, general revenue sharing and CETA had been terminated, transportation grants had increased to \$18.2 billion, AFDC-related programs cost \$11.2 billion, and Medicaid spending had soared to \$34.6 billion. Grants totalled 10.7 percent of Federal spending, and Medicaid had increased to almost 30 percent of Federal grants.

Medicaid spending for 1992 is now estimated to reach almost \$70 billion, double the level of three years previous, and may easily exceed that level. It has grown to almost 5 percent of Federal spending, and will constitute an estimated 40 percent of Federal grants. It has grown from an important part of the intergovernmental flow to the overwhelmingly dominant feature. Even the massive new highway bill will result in annual expenditures less than one-third of Medicaid's, and that fraction will shrink rapidly. Medicaid has grown

from a health financing program to the basic financial relationship between the Federal Government and the States.

The growth of the program has been made possible at both the Federal and State levels by its entitlement status and by its shared responsibility. Just as Federal lawmakers are entranced by a program for which they only have to pay 57 percent of the costs, State lawmakers are fairly easily sold on new options for which they only have to pay an average of 43 percent. It should be noted that the Medicaid program is not an entitlement for the poor—there is no guarantee to anyone of health care. The entitlement is to the State (to receive matching payments) and to the provider (to receive reimbursement at some level).

This volume presents 12 papers that depict the recent growth of the Medicaid program from a variety of perspectives. Four provide a national view, while eight present case histories in specific States. These eight States were chosen to provide a diverse presentation of small and large States and geographic location.

The *Miller* paper provides a history of Federal grant-in-aid spending and documents the change described above. It then proceeds to describe some of the consequences. Medicaid growth has been accompanied by stagnation in Aid to Families with Dependent Children (AFDC) benefits. Over the decade of the 1980s, AFDC benefits in the average State (family of three) have fallen from 80 percent of the Federal SSI benefit (couple, living apart) to 60 percent. To the extent that explicit or implicit trade-offs have been made, the paper concludes that the shift represents a tax on one group of poor to finance benefits for another group.

The *Utah* paper clearly recognizes that trade-offs were made: education and public assistance received lower funding, and there was a shift of resources within the health function itself. The *Connecticut* paper also lists the major casualties as education and public assistance. In the latter case, the enacted AFDC annual cost-of-living adjustment was repealed only three years after passage. By comparison, the *Delaware* paper concludes that few tradeoffs were made through 1991: Medicaid spending doubled over five years, but other social programs in the same agency grew by two-thirds.

Medicaid program costs have generally been underestimated at both the Federal and State levels, resulting in increases beyond the initial estimates for which trade-offs have to be made. The *Hovey* paper describes this process at the State level. The net result in the majority of States is transfers to Medicaid without explicit changes in priorities. Hovey notes that the majority of States enacted major broad-based tax increases in 1990 and 1991, using as rationales (1) "keeping the doors open" and (2) supporting education and other State functions. He adds, "not one of those tax increases was justified to legislators who voted for it or to the electorate as providing money for Medicaid. Yet comparing the spending changes to the revenue changes suggests that much of the added purchasing power did go to Medicaid." Hovey concludes that this accretion of Medicaid costs represents a transfer of resources away from the middle class, threatening the legitimacy of government provision of resources.

The growth of entitlement spending at the State level is well described in the *Connecticut* paper. Eighty percent of the State budget is estimated to be "uncontrollable," and the budget process itself therefore allows growth. Since 1986, the Medicaid program has been

the continued recipient of supplemental appropriations. Similarly, the *Indiana* paper shows that the entitlement nature of Medicaid permits it "at times to avoid immediate confrontation with other budget priorities." The Governor and Budget Director are statutorily authorized to augment the biennial appropriation to provide for underfunding that would jeopardize Federal reimbursement. Even with these augmentations, however, Medicaid still has received supplemental appropriations in even-numbered years.

Only State criminal justice expenditures have grown at a rate close to that of Medicaid. The Holden paper demonstrates that this growth has been fueled in a manner similar to that of Medicaid, in that explicit choices are rarely made. Decisions are first made in non-monetary areas such as sentencing requirements and procedures. Only later are the capital costs of prison construction recognized, followed by the ongoing costs of operations. This process produces unavoidable costs that might not have occurred if initial trade-offs had been made, with transfers to criminal justice from the balance of State spending and transfers to prisons within the criminal justice budget.

There are many reasons for State Medicaid growth. New mandates and options have been added to the system over the past five years. State perceptions of the programs were changed in some cases, such as the perceived benefits from increased maternal and child care. In addition, health costs are increasing rapidly for all levels of society, and Medicaid has shared in that growth. States have discovered that their purchasing power gives them formidable leverage in the marketplace, and the *Wesser* paper describes some of the strategies that have been pursued to control costs. These include movement to managed care systems such as prepaid health plans, waived case

management, and preferred provider arrangements; utilization review; State planning; cost shifting; selective contracting; prospective reimbursement; and cost-sharing requirements.

The *Pennsylvania* paper details the extraordinary number of amendments to the Medicaid program which the State has made since 1986. Until recently, however, those changes have not required supplemental appropriations, as an emphasis has been placed on controlling costs. In particular, fees for services reimbursed under a fee schedule (most outpatient services) were held roughly constant until the 1991-1992 budget. The *Indiana* paper describes a State that has had an expansive Medicaid program with severely constrained eligibility. As a result, few efforts have had to be made toward cost containment. The recently mandated eligibility expansions have generated substantial efforts, including the development of a nursing home reimbursement system and a DRG-type reimbursement to replace the current cost-based system. However, neither of these efforts has yet resulted in substantial reductions. The *Oregon* paper summarizes the most radical system for controlling costs, a reform that has not yet begun but is jeopardized already by a recent initiative guaranteeing increased State funds to replace locally constrained support for education.

States' abilities to finance the extraordinary growth of their Medicaid programs have been facilitated in most cases by strong own-source revenue growth through 1989, and by the growth through 1992 of the Federal Medicaid Assistance Percentage (FMAP), the differential share of each State's Medicaid program paid for by the Federal Government. A State's FMAP is an inverse function of its per capita personal income compared to the national average, and is recalculated annually.

The growing variance in the 1980s among State per capita incomes annually increased the average State FMAP through 1992. The 1992 rates are the highest since the early 1970s. However, revenue growth slowed dramatically for most States in 1990 and 1991 despite tax increases, and it is expected that 1993 will begin a process of annual FMAP decline for the majority of States.

In addition to the FMAP growth, however, the Medicaid growth was facilitated by what the *Wesser* paper describes as "expanding revenue sources" and what the *Hovey* paper terms "bootstrap financing." An increasing number of States began levying taxes on health providers to help provide the State share of Medicaid or accepting "voluntary contributions." While some of these systems resulted in a more equitable sharing of the Medicaid burden among providers, all resulted in increasing the amount of funds provided by the Federal Government without a similar burden on the State. In some States, this financing mechanism was accompanied by expansions of the definition of "disproportionate share" provider, a health provider with a high concentration of Medicaid and other poor patients.

Both the *Texas* and *Kentucky* papers describe the use of these mechanisms. Texas implemented a series of amendments to its disproportionate-share program that brought substantial amounts of new Federal funds into the State. Kentucky also used this mechanism. Both States supported these expansions through bootstrap financing, leveraging Federal dollars.

Virtually all the State papers describe an explosion of Medicaid costs that has just begun. Even without further benefit or eligibility expansions, most authors expect their States to experience major cost

increases for the foreseeable future due to (1) health cost increases, (2) changing demographics, and (3) annual increases in utilization by groups recently made eligible. The State papers suggest that both the current structure of the program and expected increases for the future may well produce a major overhaul of the way health services are financed by governments in the 1990s. Given the dominance of Medicaid in the grant-in-aid system, it can be expected that any change will also constitute a reform of the system of intergovernmental finance.



THE FINANCING AND DELIVERY OF LONG-TERM CARE SERVICES: A REVIEW OF CURRENT PROBLEMS AND POTENTIAL REFORM OPTIONS

The financing and delivery of long-term care services pose challenging public policy dilemmas. This report examines the problems of the current long-term care system and possible reform options. It also presents analyses of the costs and impacts of these selected reform options. Much of the focus is on long-term care use by the elderly population because less is known about the long-term care use of the nonelderly disabled population.⁷

The Problems of Long-Term Care

Proposals designed to reform long-term care financing and delivery must address the following problems.

The Catastrophic Costs of Long-Term Care

A 65-year-old today has about a 20-percent chance of spending a year or more in a nursing home, at an annual cost of roughly \$30,000 (in 1990 dollars). Given the lack of public and private coverage for long-term care, most people pay long-term care costs on an out-of-pocket

⁷ Although people of all ages need long-term care, about three-quarters of functionally disabled adults and 90 percent of nursing home residents are age 65 or older (Congressional Budget Office, *Policy Choices for Long-Term Care*, June 1991).

basis. As a result, many elderly and their families are impoverished by the cost of their long-term care.

The Lack of Risk Pooling for Long-Term Care

Traditionally, individuals faced with the risks of substantial economic loss choose to purchase insurance. Private insurance markets for long-term care are growing quickly, but reach less than 5 percent of the elderly. Public long-term care risk pooling is also extremely limited. Although 52 percent of the funds spent on nursing home care are provided by public programs, these programs do not provide long-term care risk pooling: Medicare's long-term care benefits aid only post-acute care patients, while the Medicaid program provides long-term care benefits to only the poor.

Variation and Lack of Access to Long-Term Care Services

The amount and type of long-term care services offered by different States vary widely, especially for home care services. Because many States have extremely limited Medicaid home care programs, there is substantial variation in the home care services offered by Medicaid. Access to nursing home services also varies geographically. In 1989, the number of nursing home beds per 1,000 persons age 65 and older in the U.S. was 52.8; nursing home bed supply ranged from a low of 26.2 per 1,000 elderly in Nevada to a high of 85.3 in Kansas. A recent GAO report documented access problems for heavy care and Medicaid nursing home patients.⁸

⁸ U.S. General Accounting Office, *Nursing Homes: Admission Problems for Medicaid Recipients and Attempts to Solve Them*, September 1990.

Questionable Quality of Some Long-Term Care Services

The quality of care in some nursing home and home care settings is poor and there is an unacceptable level of variation in the quality of public programs.^{9,10}

High and Increasing Long-Term Care Expenditures

Over \$53.1 billion was spent on nursing home care in 1990; another \$6.9 billion was spent for home care services. In the future, these expenditures will increase rapidly as services become more expensive and the size of the elderly population doubles over the next 40 years.

Options for Financing Long-Term Care

Long-term care delivery and financing reform options can be evaluated on the basis of a number of features:

- method of financing and cost of the program;
- type of covered services;

⁹ Alice Rivlin and Joshua Wiener, with Raymond Hanley and Denise Spence, *Caring for the Disabled Elderly: Who Will Pay?* Washington, DC: The Brookings Institution, 1988.

¹⁰ Nursing home reform provisions that were part of the Omnibus Reconciliation Act (OBRA) of 1987 (implemented in October 1990) set quality requirements including increasing the number of nurses on duty and nurses' aide training requirements and some requirements related to the provision of home care.

-
- eligible population and the characteristics of the beneficiaries; and
 - degree to which the risks of long-term care are pooled.

Brief descriptions of several current proposals for financing long-term care are provided in exhibit 1. The key distinguishing factor among these options is the method of financing. Each of the proposals shown could be designed to include any range of covered services and almost any eligible population. Therefore, the proposals are grouped according to whether each is (1) primarily publicly financed; (2) primarily privately financed; or (3) a combination of public and private financing.

Analysis of Selected Long-Term Care Financing Options

This report presents an analysis of six of the long-term care reform options shown in the exhibit: front-end nursing home coverage, back-end nursing home coverage, comprehensive home care, disability insurance tax credit, Medicaid spend-down insurance, and optional Medicare comprehensive coverage. The proposals are expected to increase public sector long-term care expenditures between \$0 and \$15.6 billion in the short run.¹¹ Comparing the effects of the

¹¹ The short run in this analysis was assumed to be 1993. We assumed that the proposals were fully implemented by 1993. This means that the entire effect of induced demand would be realized by 1993. An exception to full implementation was the insurance purchase assumptions, which implied gradual purchase of insurance over time under the back-end coverage proposal and the disability insurance proposal. All amounts are presented in 1992 dollars.

alternative proposals on long-term care financing and beneficiaries reveals the tradeoffs of the proposals and their implications for different groups of people (see table 1).

Among the direct service reimbursement programs in the short run (the front-end, back-end, and comprehensive home care programs), the comprehensive home care proposal serves the largest number of persons, but at the greatest cost to the government. The 2-year back-end proposal offers benefits to 1 million elderly nursing home residents, reducing out-of-pocket spending \$7.6 billion, at a cost to the government of \$10.6 billion. The front-end nursing home proposal serves the largest number of elderly beneficiaries for the smallest increase in public expenditures—\$4.9 billion.

The two programs designed to encourage the private purchase of coverage for potentially catastrophic long-term care expenses—the disability insurance tax credit and Medicaid spenddown insurance—would have little effect on long-term care financing in the short run. In the longer term, these programs are expected to have a large number of participants, up to 40 percent of the elderly. These programs would have a relatively small effect on the public financing of long-term care services but are expected to significantly offset out-of-pocket expenditures for those who participate.

Finally, the optional Medicare comprehensive coverage program is a unique method of expanding the financing of health care services to include prescription drugs and long-term care services without increasing public spending.

TABLE ES-1

SUMMARY OF LONG-TERM CARE REFORM PROPOSAL IMPACTS, 1993
(1992 dollars)

	Three-Month Front-End	Two-Year Back-End	Comprehensive Home Care	Disability Insurance Tax Credit	Medicaid Spend-Down Insurance	Optional Medicare Comprehensive ⁴
Program Benefits	\$5.2 B	\$22.4 B	\$17.3 B	\$23 M (tax credit) ¹	NA	\$0.0 B
Change in Public Spending	\$4.9 B	\$10.6 B	\$15.6 B	\$23 M	NA	\$0.0 B
Change in Out-of- Pocket Spending	\$0.3 B	-\$7.6 B	\$2.4 B	\$0.5 B	NA	NA
Number of Program Beneficiaries	1.1 M	1.0 M	2.5 M	NA ²	NA ³	3.0 M

¹ Under the Disability Insurance Tax Credit assumptions, 63 percent of the \$23 million in tax credits goes to elderly persons.

² Under the Disability Insurance Tax Credit assumptions, 3.3 million persons receive the tax credit, 42 percent of whom are elderly. Nearly 6 million persons purchase the disability insurance, 2.1 million of whom are age 65 or older.

³ Under the Medicaid Spend-Down Insurance proposal assumptions, 3.7 million elderly persons (12 percent of elderly) purchase the insurance in the short run. These purchasers do not receive any program benefits in the short run because they are not eligible to receive benefits until age 75 and after.

⁴ Results presented for the optional Medicare Comprehensive Coverage assume 10 percent of Medicare beneficiaries would participate. In the short run, very few participants would exceed the public financing threshold; therefore, program benefits would be small.

SOURCE: Lewin/ICF estimates based on results from the Brookings/ICF Long-Term Care Financing Model, 1991.

EXHIBIT 1
OPTIONS FOR LONG-TERM CARE REFORM

Reform Options	Description
PUBLICLY FINANCED	
Medicaid Reform	Increases the financial resources participants allowed to retain.
Comprehensive Social Insurance	Relies on broad-based taxation earmarked to cover cost of wide range of long-term care services for any needed care.
Front-End Nursing Home Coverage	Covers several months at start of stay so that persons who have shorter stays are able to return to the community.
Back-End Nursing Home Coverage	Starts paying benefits after 1 to 2 years of care so that persons with long stays (catastrophic costs) are assisted.
Expanded Home Care	Targets the severely disabled and/or low-income persons; most proposals include ADL-related personal care services.
PRIVATELY FINANCED	
Individual Medical Accounts (IMAs)	Allows tax-deferred contributions and interest accumulation for accounts designated for long-term care expenses.
Incentives for LTC Insurance Purchase	Examples of tax incentives include allowing private firms to offer LTC insurance as a tax-exempt fringe benefit and tax deductions and tax credits for the purchase of LTC insurance.
Accelerated Death Benefits	Allows persons in nursing homes to use the death benefits of their life insurance policies to pay for nursing home care.
Use of Pension Funds	Persons elect reduced pension benefits in exchange for (1) the purchase of long-term care insurance or (2) increased benefits upon disability.
Tax Incentives for Disability Insurance Purchase	Provides tax incentives for purchase of private insurance policies that would pay cash benefits to persons with chronic disabilities.

EXHIBIT 1 (Continued)

Reform Options	Description
PUBLIC/PRIVATE FINANCING	
Medicaid Spend-Down Insurance	Seeks to increase the purchase of long-term care insurance and reduce the number of people who deplete their assets in nursing homes by permitting individuals who purchased and used long-term care insurance to keep an increased level of assets and still qualify for Medicaid.
Voluntary Medicare Insurance	Allows Medicare beneficiaries the option to purchase government sponsored coverage, similar to the Part B coverage option where the benefits could be financed either through premiums or increased deductibles for Part A or B services.
Optional Medicare Comprehensive Coverage	Coordinates and combines both acute care services and long-term care services under one system of financing as a voluntary beneficiary option under Medicare; a private insurance plan would cover initial medical expenses up to a specified threshold and a public plan would then cover catastrophic medical expenses for beneficiaries who exceed the private financing threshold.



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